

MONTANA LEGISLATIVE HISTORY

Chapter 579 19 95

Bill H 591 S _____ Original bill & history C

H. Committee on Taxation

Hearing Date(s) Mar 21 ✓ C

Mar 23 ✓ C

_____ C

_____ C

Date Out Mar 23 ✓ C

S. Committee on Taxation

Hearing Date(s) Apr 05 ✓ C

_____ C

_____ C

_____ C

Apr 06 ✓ C

Did this bill originate in an interim committee? Yes No

Committee _____

Report _____

4/07	2ND READING CONCURRED	45	0
4/08	3RD READING CONCURRED	48	0
	RETURNED TO HOUSE		
4/10	SIGNED BY SPEAKER		
4/11	SIGNED BY PRESIDENT		
4/11	TRANSMITTED TO GOVERNOR		
4/14	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 440		
	EFFECTIVE DATE: 04/14/95		

HB 589 INTRODUCED BY GRADY, ET AL.

EXEMPT LODGES AND CLUBHOUSES OF FRATERNAL ORGANIZATIONS
FROM THE BENEFICIAL USE PROPERTY TAX

3/09	INTRODUCED		
3/09	FIRST READING		
3/09	REFERRED TO TAXATION		
3/10	FISCAL NOTE REQUESTED		
3/14	FISCAL NOTE PRINTED		
3/21	HEARING		
3/23	COMMITTEE REPORT—BILL PASSED		
3/24	2ND READING PASSED	70	27
3/25	3RD READING PASSED	74	23
	TRANSMITTED TO SENATE		
3/27	FIRST READING		
3/27	REFERRED TO TAXATION		
4/03	HEARING		
4/04	TABLED IN COMMITTEE		
	DIED IN COMMITTEE		

HB 590 INTRODUCED BY FUCHS, ET AL.

ESTABLISH A BLUE RIBBON TASK FORCE TO EXAMINE ALL ASPECTS OF
TAXATION IN MONTANA AND MAKE RECOMMENDATIONS TO THE
GOVERNOR AND LEGISLATURE ON SHORT-TERM AND LONG-TERM TAX
POLICY STRATEGIES

3/09	INTRODUCED		
3/09	FIRST READING		
3/09	REFERRED TO TAXATION		
3/15	HEARING		
3/22	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/24	2ND READING DO PASS MOTION FAILED	35	65

HB 591 INTRODUCED BY WISEMAN, ET AL.

PROVIDE FOR A STATEWIDE TRAUMA CARE SYSTEM
BY REQUEST OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL
SCIENCES

3/09	INTRODUCED		
3/09	FIRST READING		
3/09	REFERRED TO TAXATION		
3/10	FISCAL NOTE REQUESTED		
3/16	FISCAL NOTE RECEIVED		
3/16	FISCAL NOTE PRINTED		
3/21	HEARING		
3/23	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/24	2ND READING PASSED AS AMENDED	51	49
3/27	3RD READING PASSED	57	37
	TRANSMITTED TO SENATE		
3/28	FIRST READING		

3/28	REFERRED TO TAXATION		
4/05	HEARING		
4/06	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/07	2ND READING CONCURRED	48	0
4/08	3RD READING CONCURRED	43	5
	RETURNED TO HOUSE WITH AMENDMENTS		
4/10	MOTION FAILED TO CONCUR WITH AMENDMENTS ON 2ND READING	43	55
	SENATE		
4/12	REQUESTED HOUSE TO RETURN BILL TO SENATE IN ORDER TO PLACE BILL ON 2ND READING	48	1
4/12	(HOUSE RETURNED BILL TO SENATE)		
4/12	2ND READING CONCURRED AS AMENDED	47	2
	(TEXT OF BILL UNCHANGED BY SENATE AMENDMENTS)		
4/13	3RD READING CONCURRED	44	6
	TRANSMITTED TO HOUSE		
4/14	SIGNED BY SPEAKER		
4/18	SIGNED BY PRESIDENT		
4/18	TRANSMITTED TO GOVERNOR		
5/01	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 579		
	EFFECTIVE DATE: 05/01/95—SECTIONS 4(2), 12 & 13		
	EFFECTIVE DATE: 10/01/95—SECTIONS 1-3, 4(1), 4(3), 4(4) & 5-11		

HB 592 INTRODUCED BY JORE

IMPLEMENT THE GENERAL APPROPRIATIONS ACT FUNDING FOR SCHOOL
EQUALIZATION AID BY REVISING THE BASIC ENTITLEMENT FOR
SCHOOL DISTRICTS AND THE PER-ANB ENTITLEMENT

3/09	INTRODUCED		
3/09	FIRST READING		
3/09	REFERRED TO APPROPRIATIONS		
3/10	FISCAL NOTE REQUESTED		
3/16	FISCAL NOTE RECEIVED		
3/16	FISCAL NOTE PRINTED		
3/20	HEARING		
3/21	TABLED IN COMMITTEE		
3/24	MISSED TRANSMITTAL DEADLINE FOR 67TH DAY DIED IN COMMITTEE		

HB 593 INTRODUCED BY DENNY, ET AL.

REDUCE PUBLIC SERVICE COMMISSION FROM FIVE MEMBERS TO THREE
MEMBERS

3/11	INTRODUCED		
3/11	FIRST READING		
3/11	REFERRED TO STATE ADMINISTRATION		
3/13	FISCAL NOTE REQUESTED		
3/15	HEARING		
3/16	FISCAL NOTE RECEIVED		
3/16	FISCAL NOTE PRINTED		
3/20	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/24	2ND READING PASSED	64	35
3/25	3RD READING PASSED	63	35
	TRANSMITTED TO SENATE		
3/27	FIRST READING		
3/27	REFERRED TO BUSINESS & INDUSTRY		
3/30	HEARING		

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0591, as introduced

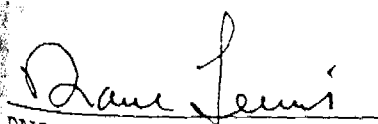
DESCRIPTION OF PROPOSED LEGISLATION:

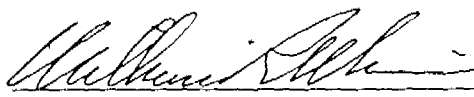
An act providing for a statewide trauma care system; creating an emergency medical services advisory council and a trauma care committee; requiring the Department of Health and Environmental Sciences (DHES) to create and administer the system; requiring DHES to adopt rules; providing for designation of trauma care facilities; providing for regional trauma care advisory committees; providing for confidentiality of trauma data and quality improvement records; providing for a grant-in-aid program; imposing a fee on certain vehicles; and providing an appropriation.

ASSUMPTIONS:

1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation.
2. During calendar year 1994, 813,694 passenger cars, trucks, buses and motor homes were registered in the state of Montana.
3. HB591 implements a new fee of \$.90 on registration of certain vehicles effective January 1, 1996, which increases to \$1.20 on January 1, 1997. Of the fee, beginning January 1, 1996, and throughout the remainder of the biennium, \$.70 is deposited to a grant-in-aid state special revenue account. From January 1, 1996, through December 31, 1996, the remaining \$.20 is deposited in the trauma system implementation state special revenue account. When the fee increases on January 1, 1997, the additional \$.50 is deposited to the trauma system implementation state special revenue account.
4. Fees deposited to the state special revenue fund for the trauma system grant-in aid account would be approximately \$284,793 in FY96 (813,694 vehicles registered annually divided by 1/2 which represents 6 months (January through June 1996) x \$.70 per vehicle registered] and \$569,586 in FY97 [813,694 vehicles registered annually x \$.70 per vehicle registered].
5. Fees deposited to the state special revenue fund for the trauma system implementation account would be approximately \$81,369 in FY96 (813,694 vehicles registered annually divided by 6 months (January through June 1996) x \$.20 per vehicle registered) and \$284,793 in FY97 [813,694 vehicles registered annually divided by 1/2 which represents 6 months (July through December 1996 x \$.20 per vehicle registered plus 813,694 vehicles registered annually divided by 1/2 which represents 6 months (January through June 1997) x \$.50 per vehicle registered].
6. There would be an expenditure of \$4,900 to restructure the motor vehicle computer program, in the Department of Justice Motor (DoJ) Vehicles Division, and expand the total number of fees that the system records, in order to accommodate the new fee.
7. DHES will hire a trauma nurse coordinator and clerical staff beginning on January 1, 1996, for purposes of implementing and coordinating the statewide trauma system. These positions are reflected as 1.00 FTE additional in FY96 and 2.00 FTE in FY97.

(continued)

 3-16-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning


WILLIAM WISEMAN, PRIMARY SPONSOR DATE

Fiscal Note for HB0591, as introduced

HB 591

(continued)

FISCAL IMPACT:Expenditures:

	<u>FY96</u>	<u>FY97</u>
	<u>Difference</u>	<u>Difference</u>
FTE	1.00	2.00
Personal Services (DHES)	29,629	59,258
Operating (DHES)	46,840	225,535
Operating (DoJ)	4,900	0
Grants to Locals	<u>284,793</u>	<u>569,586</u>
Total Expenditures	366,162	854,379

Funding:

State Special Revenue (02)	366,162	854,379
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Revenues:

Trauma System Grant-in-Aid (02)	284,793	569,586
Trauma System Implementation (02)	<u>81,369</u>	<u>284,793</u>
Total Revenues	366,162	854,379

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:

Due to the staggered fee implementation schedule the trauma system implementation account would receive approximately \$406,847 in FY98 (813,694 vehicles registered annually x \$.50 per vehicle) which is an increase of \$122,054 from FY97. A major portion of this money will be used to provide funding assistance to local emergency medical services and facilities to assist them in improving their trauma care systems.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

It is estimated that about 20% of Montana deaths could be prevented through establishment of an organized trauma care system. Using a computer program provided by the National Highway Traffic Safety Administration, the department estimates the total economic costs of fatal automobile crashes in Montana during 1992 was \$141,271,104. (Montana loses an average of 30 years of productivity and taxable earnings every time a person dies from injury. The estimated lifetime cost of each injury death is about \$450,000.) When all automobile crashes are considered, the economic cost of automobile injuries in Montana during one year is estimated at \$262,188,518.

the organization was unfairly taxed, they should receive a rebate.

REP. HARPER said he understood the issue came about when the beneficial use tax was amended and it went into effect at the beginning of 1993 so the effective date would make sure the exclusion covered the same period that the act covered. Dave Woodgerd, DOR Attorney, said that was also his understanding. He also agreed that the Helena Elks Lodge was the only organization affected by the bill.

REP. REAM asked what the tax situation was for lodges located on their own land. Mr. Woodgerd said fraternal lodges with a food and beverage operation are subject to the beneficial use tax.

REP. ELLIOTT asked if the Helena lodge had a food and beverage operation. Mr. Boe said they did.

Closing by Sponsor:

REP. GRADY commented that passing this bill would be a matter of fairness. He asked for the Committee's favorable action.

HEARING ON HB 591

Opening Statement by Sponsor:

REP. WILLIAM WISEMAN, House District 41, Great Falls, said HB 591 would establish a state-wide trauma system for the State of Montana. He said he had learned that there is a tremendous problem in the state with injuries and deaths that occur from trauma. Many of these are preventable. Everyone in Montana is affected by the lack of a trauma system. He said a task force of health professionals have expended a great deal of time developing a plan for trauma care. They are now asking for help in implementing the plan. The system is voluntary and does not involve a high bureaucratic regime of any sort. REP. WISEMAN said it's a case of "spending a little money now or paying a whole lot of money later on." A lack of instant response at the time of an accident can lead to prolonged, expensive hospitalization. EXHIBIT 2.

Proponents' Testimony:

Stuart Reynolds, Havre, stated that he was a surgeon, practicing in Montana for 26 years, and he has been involved with emergency medical services since 1972. He said there is an epidemic in Montana and individuals in rural areas are at a high risk. In 1992, 600 people died in Montana from trauma with 174 occurring on highways. He said a number of these people could be saved if there was an effective trauma system in the state, and the amount of disability could be reduced substantially. An outline of Dr. Reynolds' testimony is attached. EXHIBIT 3.

John Middleton, M.D., Chairman of the Montana Committee on Trauma, addressed the issue of what has been done so far in Montana. He said it has been proven that deaths can be prevented where there is an effective trauma system. The two issues included in the plan are optimal use of existing resources and the emphasis will be on facilitation. An outline of his testimony is attached. EXHIBIT 4.

{Tape: 1; Side: B.}

Robert N. Hurd, M.D., Surgeon, Billings, discussed the need for trauma legislation. A copy of his testimony is attached. EXHIBIT 5.

Susan O'Leary, Trauma Coordinator, provided a written copy of her testimony covering the reasons there is a need for a trauma system. EXHIBIT 6.

Sharon Dieziger, Montana Nurses' Association, and Statewide Trauma Task Force Member, testified in support of the bill. She stated that there is a need to prepare and educate the smallest and most isolated communities in Montana on what to do and how to safely transport trauma patients. Trauma does not occur just in the cities. Her written testimony and supporting document are attached. EXHIBIT 7.

Gary Haigh, Montana EMS Association, Billings, spoke in support of the bill. He provided an example of a football injury that occurred in a small town which did not have an ambulance. The person was transported in the back of a stationwagon, and when they arrived at a hospital 90 miles distant, the hospital was not expecting them and was unable to provide the needed care resulting in transfer to another facility, further delaying appropriate care. He said this convinced him to become involved in emergency medical services and work toward the creation of a better system. If a trauma system had been available, he was convinced that costs of rehabilitation of the injured player would have been considerably less. He said trauma is an expensive health problem in Montana and the cost of an effective trauma system would be well worth the cost. Mr. Haigh said the Task Force is suggesting an increase in motor vehicle registration fees to fund the trauma plan, \$.90 the first year and \$1.20 per year from then on. He said this method was chosen because 50% of trauma deaths are due to motor vehicle crashes and a substantial amount of non-fatal injuries are due to motor vehicle accidents. The majority of funds collected would be returned to local areas for quick response units, ambulance services and medical facilities, to assist with improving education and training and to help obtain essential equipment. The advisory council of the State Trauma Committee would make recommendations to the Department on how the funds could best be utilized to improve trauma care consistent with the trauma system plan and data evaluation results. The remainder of the funds would be used for data collection and evaluation at both the pre-

hospital and hospital levels, education and training, public education and prevention activities, and state level coordination. EXHIBIT 8. He thanked the Committee for their support.

Nels D. Sanddal, President and CEO, Critical Illness and Trauma Foundation, Inc., Big Timber, said trauma is a major public health problem in Montana. What makes the tragedy even more devastating is that so many of the deaths could be averted with a state-wide trauma system. Mr. Sanddal's remarks are contained in EXHIBIT 9.

Paul Donaldson, M.D., Helena, testified regarding the need for updated physician education related to trauma management. EXHIBIT 10.

Jim Ahrens, President, Montana Hospital Association, said he had been involved in the process and he encouraged the Committee to recognize the amount of work done by the Task Force and support the bill.

Tim Bergstrom, Montana State Firemens' Association, said the Association is in strong support of HB 591. A copy of his testimony is attached. EXHIBIT 11.

Tom Ebzery, Attorney, St. Vincent's Hospital, Billings, called the Committee's attention to an editorial which appeared in the *Billings Gazette* on March 20, 1995, relative to HB 591. He urged the Committee to support the bill. EXHIBIT 12.

James Lofftus, Montana Fire Districts Association, said the bill would encourage training for people in volunteer fire districts. He said he had seen cases where deaths could have been prevented if there had been a better knowledge of trauma care. He asked for the Committee's favorable support.

John Gervais, President, Montana Emergency Medical Services Association, said the members of his organization are pre-hospital care providers, the majority of which are associated with rural volunteer emergency medical service entities. They strongly support the bill. Mr. Gervais' testimony and a copy of a Resolution on Trauma System and Trauma System Legislation is attached. EXHIBIT 13.

Beda Lovitt said the Montana Medical Association strongly supports HB 591.

Steve Yeakle, Montana Council of Maternal and Child Health, testified in support of the bill. He provided statistics on the causes of death in Montana and advised that 44% of the deaths of children between the ages of one and four, were attributable to trauma. In the age group 15 through 24, 60% were from injury and in ages 5 through 14, two of every three deaths were caused by

trauma. He said a trauma plan system has reduced the death rates in other states.

Bob Robinson, Director, Department of Health and Environmental Services, said he would support the bill on behalf of the Department and also on behalf of Governor Racicot. He said the Governor has monitored the development of this legislation and believes the bill is well-designed and there is a need to address the problem immediately. He said approval of the bill and establishment of the Montana Trauma System would have an immediate effect.

CHAIRMAN HIBBARD stated that Alec Hanson, League of Cities and Towns, was unable to attend the hearing but had asked to go on record in support of the bill.

{Tape: 2; Side: A.}

Opponents' Testimony:

Steve Turkiewicz, Montana Auto Dealers Association, said the Association is extremely concerned and sympathetic to the problems of EMT responses and have furnished over a hundred training manikins to Montana rural EMT providers and other training organizations. He said there are problems with emergency health care and the bill would go a long way to address some of the problems. He said many communities do not have ambulances that meet federal regulations because they cost between \$80,000 and \$100,000 and he realized the problem must be addressed. He said the Association's opposition to the bill is based on the funding method. He said \$70 million is paid annually by Montana motor vehicle owners and adding another million dollars would not be the correct thing to do. He said the registration form would have to be expanded to add one more fee. EXHIBIT 14. If a fee is to be assessed, it should be extended to snowmobiles and motorcycles that contribute to the trauma rate. He said the bill would establish an entirely new health care system and it should be the responsibility of the Select Health Care Committee to look at the bill to determine how it would coordinate with the Health Care Authority and the Health Care Advisory Committee. He said he did not oppose the idea of a health care system but he asked the Committee to consider carefully who would be paying for it. If the entire state and all its citizens are to benefit, perhaps a broader base of revenue should be found.

Questions From Committee Members and Responses:

REP. ELLIOTT asked, if automobiles are the first leading cause of trauma, what would be the second. Dr. Reynolds said drowning, motorcycles, falls from heights, lumbering accidents are all high impact. They also look at homicides, suicide, environmental such as hypothermia, fire, low falls, poisoning and "surgical

misadventures." However, the overwhelming majority come from automobiles and the others don't come close.

REP. ELLIOTT said the Governor supports the concept of the bill. He asked if he also supported the system of taxation. Mr. Robinson said the Governor approved the bill, therefore, he assumed he would support the method of funding. REP. ELLIOTT said trauma is not the fault of the automobile industry. He asked if it wouldn't be more appropriate to provide funding through the general fund. If the program is that important, that is where the funding should come from. Mr. Robinson said funding was a serious issue the Task Force worked on. Realistically, they considered the ability to go to the general fund would not be feasible. The Task Force felt this was probably the "cleanest" way to generate the level of revenue needed that would be politically palatable. REP. ELLIOTT asked Mr. Robinson if he would ask Governor Racicot if he would support funding of the bill with general fund money. Mr. Robinson said he would.

REP. SOMERVILLE asked if the system would be set up on a county system. Dr. Reynolds said the state would be divided into three regions because there are three communities (Missoula, Great Falls and Billings) that have hospitals that have obtained Level Two trauma center status. A patient would be brought into the system at the nearest hospital for appropriate resuscitation and possible treatment and, if necessary, the patient would be transferred to one of those three cities for definitive care. He said the system is in place and what needs improvement is the initial response. REP. SOMERVILLE said he had noted that all boards identified in the bill were composed of medical personnel. He asked if it would be appropriate to amend the bill to add legal or accounting personnel to the boards. Dr. Reynolds said he would agree with the suggestion. However, the Governor could appoint up to ten members from any group he wished. He said there were consumer members on the Task Force.

REP. ARNOTT said she did not understand the statement given in testimony that caregivers should come together "without fear of legal discovery." Ms. O'Leary said that meant that a group should be able to discuss a patient that had a "less than excellent outcome." They would discuss how they could do it better or where the system might have failed. It would be hard to hold those discussions if the information was available for trial.

REP. SWANSON asked how the education would be provided to meet the needs of rural areas. Mr. Gervais said they now do all their training voluntarily and pay all their own expenses. The system would provide, through CD-ROM or video, training locally without having to travel many miles. They could get all first responders trained at the same level. When they go to an accident, they could approach it knowing there is a trauma center to which the victim could be sent directly if they feel the local hospital couldn't handle it.

{Tape: 2; Side: B.}

REP. SWANSON asked what the most important aspect of the bill would be. Mr. Gervais said, in his opinion, training would be the major issue, but he also recognized that a lot of areas need better equipment.

REP. BOHLINGER asked if the sponsor would consider expanding the bill to include taxation of motorcycles, water craft or snowmobiles. REP. WISEMAN said the program could start with taxation of automobiles and statistics could be kept on the number of injuries coming from other vehicles and make a determination at a later date.

REP. FUCHS asked if the Task Force had considered alternative methods of funding. REP. WISEMAN said they had looked everywhere for funding and still felt that, since the majority of accidents come from automobiles, it would make sense to put the fee there.

REP. STORY said a Senate Bill had been introduced to eliminate earmarking of funds. He asked whether that would affect this program. REP. WISEMAN said it could but earmarked money on car licenses has existed for a long time. He said it might be possible to de-earmark junk vehicles and earmark the trauma system.

REP. REAM asked if there was any data available on whether quick response was important in minimizing long-term disability. Dr. Reynolds said there was. He said that if the first response was not managed appropriately, if there was reduced blood flow or oxygen, there would be further damage. If not well managed at the onset, there would be increased disability. When a trauma system is in place, more information can be collected, and public education programs can be directed specifically to areas of high risk. This is a major component of trauma system development.

Closing by Sponsor:

REP. WISEMAN advised that there would be two amendments to the bill, although only one had been prepared. EXHIBIT 15. He said he appreciated the good hearing and he acknowledged the good testimony and good questions. He reminded the Committee that 17 states have trauma systems in existence and they have proven to be effective. He said the vehicle tax was a fair way to provide funding. He said 600 people die every year in accidents and it has been estimated that at least 100 could be saved if Montana had a trauma system. He said the junk vehicle fee has been revoked and it could be replaced with the trauma system fee because "people are more important than junk vehicles."

HOUSE OF REPRESENTATIVES

Taxation

ROLL CALL

DATE March 21, 1995

NAME	PRESENT	ABSENT	EXCUSED
Rep. Chase Hibbard, Chairman	✓		
Rep. Marian Hanson, Vice Chairman, Majority	✓		
Rep. Bob Ream, Vice Chairman, Minority	✓		
Rep. Peggy Arnott	✓		
Rep. John Bohlinger	✓		
Rep. Jim Elliott	✓		
Rep. Daniel Fuchs	✓		
Rep. Hal Harper	✓		
Rep. Rick Jore	✓		
Rep. Judy Rice Murdock	✓		
Rep. Tom Nelson	✓		
Rep. Scott Orr	✓		
Rep. Bob Raney	✓		
Rep. Sam Rose	✓		
Rep. Bill Ryan	✓		
Rep. Roger Somerville	✓		
Rep. Robert Story	✓		
Rep. Emily Swanson	✓		
Rep. Jack Wells	✓		
Rep. Ken Wennemar	✓		

The Effect of Regional Trauma Care Systems on Costs

Ted R. Miller, PhD, David T. Levy, PhD

EXHIBIT 2
DATE 3/21/95
HB 591

Objective: To assess cost savings from regional trauma care systems.

Design: Multivariate regression analysis is used to isolate the effects of regional trauma care systems on medical costs while controlling for personal and injury characteristics and other factors likely to influence medical costs. Percentage reductions in costs are translated into dollar cost savings with corrections for excluded costs and losses from premature death.

Setting: Injuries to workers filing workers' compensation lost workday claims.

Participants: Randomly sampled workers' compensation claims from 17 states filed between 1979 and 1988 (N=217 000).

Main Outcome Measure: Medical payments per episode of four injury groups: lower-extremity fractures and

dislocations, upper-extremity fractures and dislocations, other upper-extremity injuries, and back strains and sprains. We distinguish hospitalized from nonhospitalized claims.

Results: Statistical analyses reveal that states with trauma care systems have 15.5% lower costs per hospitalized injury episode. Savings average \$1025 per case in 1988 dollars. Costs per episode for disabling nonhospitalized injury are 10% lower in states with trauma care systems, with savings averaging \$73 per case. The largest savings are for back injuries.

Conclusions: Extending trauma care systems nationwide could lower annual medical care payments by \$3.2 billion. Including productivity losses due to premature death, the savings could total \$10.3 billion, 5.9% of national injury costs.

(Arch Surg. 1995;130:188-193)

A TRAUMA care system is designed to meet the needs of seriously injured people in a region. Champlon and Mabee¹ describe its components as emergency response that performs triage and administers prompt, advanced prehospital life support; committed hospitals that provide state-of-the-art trauma care in accordance with guidelines of the American College of Surgeons; and inpatient and outpatient rehabilitation. The Trauma Care Systems Planning and Development Act of 1990 authorized a federal grants program to promote the development of regional trauma care systems.

Several studies²⁻⁷ have shown that trauma care systems reduce the preventable trauma death rate by at least 20% to 30%, perhaps even 50%. Champlon and Mabee¹ estimate that organized trauma care systems nationwide could save 20 000 to 25 000 lives annually. Despite this po-

tential, there has been no definitive study of the overall cost-effectiveness of regional trauma care systems.¹

Trauma care systems are costly. Even if they improve outcomes, they may not reduce overall health care costs. For example, by increasing the rate of survival, trauma care may increase the length of hospital stay and, thus, the cost for more critically injured patients. This study is the first broadly representative analysis of the impact of trauma care systems on injury costs. We focus on total medical care payments for disabling nonfatal workplace injuries, including payments in the acute-care and rehabilitation phases.

From the Safety and Health Policy Program, National Public Services Research Institute, Landover, Md (Dr Miller); and the Department of Economics, University of Baltimore (Md) (Dr Levy).

See Invited Commentary at end of article

METHODS

DATA SOURCES AND SAMPLE

Our analysis relies primarily on the Detailed Claims Information (DCI) database of the National Council on Compensation Insurance (NCCI). The DCI database describes the medical and ancillary payments and long-term economic loss associated with workplace injury. It records claims payments by year for a simple random sample of workers' compensation lost workday claims. The DCI file includes 17 states from 1979 to 1988. States were chosen to constitute a nationally representative cluster sample. To keep the sample representative, the states included in the file were revised following population shifts discovered from the 1980 census.⁸ The states and years included are presented in Table 1.

The DCI data are restricted to disabling claims from a working-age population and a single payment source. In most states, workers' compensation pays the full charge for medical care. The number of lost days required to qualify as a lost workday claim, however, varies by state, with a range from 2 to 7 and an incidence-weighted mean of 4.⁹ Four states had hospital and medical fee schedules for workers' compensation throughout the data-collection period; one state had just a medical fee schedule. Three states implemented fee schedules partway through the period.¹⁰

The DCI record includes hospital payments (no co-payment is required in the system); medical payments covering professional services, prescriptions, equipment, long-term medical care, and vocational rehabilitation; length of stay if hospitalized; disability compensation; and classification as total temporary, partial permanent, or total permanent disability. The record also includes the person's most severe injury by a two-digit code for the body part and a two-digit code for the nature of the injury (eg, finger fracture) using the American National Standards Institute's Z-16.2 injury coding system.

For each claim in the DCI sample, the insurer reports data 6 months after the injury and annually thereafter until the claim is closed (ie, no more payments are anticipated, or a reserve is set aside to cover predictable future payments). Claims are reopened if unanticipated payments arise after closure.

The original DCI file for this study contains data on 452 000 injury incidents, including 138 000 with hospitalization. In deriving the sample used in this study, we restrict the entire DCI sample in two ways. First, we limit the cases to four major groups of injuries constituting about half of the DCI file (229 000 cases): upper-extremity fractures, dislocations, and ruptures; other upper-extremity injuries; lower-extremity fractures, dislocations, and ruptures; and back sprains and strains. We do not analyze brain injuries or internal injuries because DCI data do not describe these injuries well. For example, all internal organs except the heart are coded as body part 48. Availability of adequate sample cases for other types of injury further constrain the choice of injury.

Because our sample includes three trauma care systems implemented between 1985 and 1987, claims within the sample from the period before trauma systems were implemented would have had more years to mature than claims made after implementation. Inclusion of longer-standing closed claims would tend to bias the analysis

toward greater effectiveness (because of shorter maximum treatment duration) of trauma care systems. To avoid this potential source of bias, we omit claims in which costs beyond the reserve established for the claim were incurred more than 18 months after injury. For the injury types we studied, approximately 2% of nonhospitalized injuries and 16% of hospitalized injuries are excluded as open claims or claims not closed within 18 months. Our final sample includes 217 067 claims.

DEFINITION OF TRAUMA CARE SYSTEMS

The years in which states in the DCI sample had trauma care systems are reported in Table 1. The DCI data include states where trauma care system status changed over time as well as states where systems either were in place continuously or were never implemented. Marcia Mabce, PhD, who monitors trauma care systems development for the Eastern Association for the Surgery of Trauma, identified the states with trauma care systems. Dates of operation and extent of coverage were verified by telephone.

STATISTICAL ANALYSIS

We compare the means of medical care payment by major injury group and hospitalization status for states with and without trauma care systems. However, mean differences do not control for other factors that may cause variations in medical payments, such as nature of injuries, other state-related factors, and year of occurrence. Multivariate regression is employed to distinguish the cost effects of trauma care systems from other contributing factors. We estimate separate regressions by hospitalization status for each of the four groups of injuries discussed above.

The cost equations explain variations in total medical and ancillary payments per injury episode. The equations include person-specific variables (age, age squared, length of hospital stay, time before the claim is closed, duration of total temporary disabilities, and separate indicator variables [0 vs 1] for specific body part injured, nature of injury, whether permanently disabled, and sex), state-specific variables (days lost required to qualify for workers' compensation, fraction of the population living in metropolitan areas, average Medicare-covered charge per covered day of short-stay hospital care, indicator variable designating whether the injury occurred in a state with a trauma system, separate indicator variables for whether the state had hospital charge controls or a medical fee schedule in workers' compensation, and indicator variables for geographic region), and year-specific indicator variables. The payment data and state-specific hospital price index by year are inflated to 1988 dollars using the medical care component of the consumer price index.

Because the distribution of medical payments begins at \$0 and has a long upper tail, the payment variable is converted to natural logarithm form. Consequently, each regression coefficient estimates the fractional change in payments resulting from a unit change in the relevant variable.

CALCULATION OF NATIONAL COST SAVINGS

To estimate cost savings from nationwide implementation of trauma care systems, we proceed in three steps.

Continued on next page

We first calculate the effect on total costs for the four injury groups included in our statistical analysis. We multiply estimated medical payment savings per case (obtained from the regression equations) by estimated national incidence for each injury grouping and hospitalization status. Hospitalized injury incidence is obtained from annual National Hospital Discharge Survey (NHDS) case counts for 1984 through 1986. Readmissions are removed from the counts using the method suggested by Rice et al.¹¹ Normally, injuries are considered to have International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), diagnosis codes between 800 and 999. Since the DCI data for back injuries include displacement of thoracic or lumbar intervertebral disk without myelopathy, ICD 722.1 (which is the 10th-leading hospital discharge diagnosis), we add its case count to back counts (obtained from Lemrow et al.¹²). To estimate the incidence of nonhospitalized disabling injuries, we assume that the percentage of hospitalized disabling injuries that the DCI captures in the four injury groupings combined equals the percentage of nonhospitalized disabling injuries that the DCI captures in these groupings. The probability of hospitalization for disabling injuries is assumed to be the same for workers' compensation cases as for other injury cases. Non-hospitalized injury incidence is calculated as DCI nonhospitalized counts in each injury category divided by the percentage of hospitalized injuries in the category included in the DCI data.

To incorporate cost savings for body regions not included in our statistical analysis, we divide the savings for analyzed injuries by the percentage of total injuries analyzed. The four injury groupings analyzed include 49.4% of all nonfatal hospitalized injuries. Lower-extremity fractures and dislocations alone account for 18.5% of nonfatal hospitalized injuries.

Finally, we compute the effects of fatality reduction. We use Champion and Teier's³ lower boundary estimate of 20 000 lives saved by nationwide trauma systems. We incorporate medical costs and costs of lost productivity. Champion et al.³ found that most deaths prevented involve injuries with Abbreviated Injury Scale scores of 3 or higher. Therefore, we subtract the higher injury costs of nonfatal injuries from the medical costs associated with fatal injuries. From Miller et al.,¹³ we assume that medical payments per case would rise from \$5859 per death (including costs of a premature funeral) to the average of \$28 638 paid for nonfatal highway crash injuries with Abbreviated Injury Scale scores of 3 or higher (adjusted from a 4% discount rate to the 6% rate that Rice and colleagues¹¹ used). An estimate of productivity savings is obtained from the same source (\$395 037). Subtracting adjusted nonfatal injury productivity costs (\$39 366), costs per death are \$355 671. Since highway crash injuries involve more force than most, this procedure may overestimate the costs per nonfatal injury. In that event, cost savings from deaths are underestimated. Our estimates of fatality costs do not include the loss in quality of life due to decreased survival.

Table 1. States Included in the DCI Sample, Years Sampled, and Existence and Status of Trauma Care Systems*

State	Years Sampled	Years With Trauma Care
Connecticut	1979-1983	
Florida	1979-1988	1983-1988
Georgia	1979-1984, 1987-1988	
Hawaii	1983-1988	
Illinois	1979-1988	1979-1988
Kentucky	1979-1988	
Louisiana	1984-1988	
Maine	1980-1988	
Massachusetts	1979-1988	1979-1988
Michigan	1975-1988	
Minnesota	1979-1988	
New Mexico	1988-1988	1988-1988
New York	1979-1983	
Oregon	1983-1988	1985-1988
Pennsylvania	1979-1988	10/1987-1988
Virginia	1979-1984	1981-1984
Wisconsin	1979-1983	

*DCI indicates Detailed Claims Information.

Table 2. Effects of a Trauma Care System on Workers' Compensation Medical Payments per Hospitalized Injury Victim

	Medical Payment per Victim, \$			
	Upper-Extremity Fracture	Other Upper-Extremity Injury	Lower-Extremity Fracture	Back Sprain
With trauma care system				
Mean payment	5449	4168	6771	5997
SD	6242	5346	7581	6846
No. of cases	1033	2614	1082	3406
Without trauma care system				
Mean payment	5860	4576	7511	6511
SD	13 496	5297	16 036	13 819
No. of cases	3356	8535	3793	11 563
	Regression Results			
% Savings with trauma care	9.7*	14.4*	18.1*	16.4*
df	4355	11 111	4781	14 943
Adjusted R ²	.323	.337	.521	.351

*P < .01 by two-tailed test.

RESULTS

IMPACTS ON COSTS PER EPISODE OF HOSPITALIZED AND NONHOSPITALIZED INJURY

Table 2 presents the mean medical payments per hospitalized injury episode for states with and without trauma care systems and summarizes the regression results on treatment costs per hospitalized injury. The mean medical payments per episode are between about 4% (for upper-extremity fractures) and 10% (for other injury groups) lower

Table 3. Dollar Savings in Medical Payments for Hospitalized Injuries Expected From Sound Nationwide Trauma Care Systems

	Savings per Case, \$	Cases per Year	Total Savings per Year, \$ (in Millions)
Upper-extremity fracture	544	210 676	114.6
Other upper-extremity injury	645	131 441	84.8
Lower-extremity fracture	1329	492 700	655.0
Back sprain/strain	1030	482 260	496.5
Mean/Total	1026	1 317 077	1 359.9

Table 4. Effects of a Trauma Care System on Workers' Compensation Medical Payments per Nonhospitalized Injury Victim

	Medical Payment per Victim, \$			
	Upper-Extremity Fracture	Other Upper-Extremity Injury	Lower-Extremity Fracture	Back Sprain
With trauma care system				
Mean payment	743	510	678	652
SD	899	826	889	1720
No. of cases	4251	15 790	3363	20 155
Without trauma care system				
Mean payment	756	568	706	685
SD	1727	1434	922	1152
No. of cases	14 439	49 453	11 570	62 721
Regression Results				
% Savings with trauma care	5.5*	8.3*	6.9*	17.0*
df	18 654	65 206	14 905	82 852
Adjusted R ²	.259	.258	.334	.210

*P < .01 by two-tailed test.

for states with trauma care systems, but the means are subject to relatively large SDs.

The regression equations explain about 50% of the variation in payments for lower-extremity fractures and about 30% for the other three injury types. The coefficient for trauma care systems is negative and statistically significant at the 99% confidence level or higher in all cases. The effects of other explanatory variables (available from the authors) are as expected: States where more days lost are required for inclusion in the data set (and that thus include only more severe injuries) have higher costs per incident. Permanently disabling injuries and injuries with longer hospital stays also have higher costs. It costs less to treat younger workers for nonfractures. Workers' compensation cost controls lower hospitalized injury payments.

In states with a trauma care system, comparable hospitalized injuries cost on average between 10% and 18% less to treat. The reductions in payments per case and total payments are presented in **Table 3**. Multiplying by mean payments per case reveals savings averaging \$1025 per case (15% of costs) for temporarily or permanently

Table 5. Dollar Savings in Medical Payments for Disabling Nonhospitalized Injuries Expected From Sound Nationwide Trauma Care Systems

	Savings per Case, \$	Cases* per Year	Total Savings per Year, \$ (in Millions)
Upper-extremity fracture	41	896 893	37.1
Other upper-extremity injury	35	769 182	26.8
Lower-extremity fracture	48	1 528 547	73.8
Back sprain/strain	115	2 670 069	306.4
Mean/Total	75	5 854 790	444.2

*Restricted to disabling nonhospitalized injuries.

Table 6. Estimated Cost Savings (in 1988 Dollars) If Sound Trauma Care Systems Were Implemented Nationwide

	Medical Payments, \$ (in Millions)	Productivity Losses, \$ (in Millions)	Total, \$ (in Millions)
Reduced cost per case	1800		1800
Injuries not studied	1840		1840
Increased survival	(450)*	7110	6660
Total	3190	7110	10 300

*Parentheses indicate additional cost.

disabling hospitalized injuries. Annual savings total about \$200 million for all upper-extremity cases, \$650 million for lower-extremity cases, and \$500 million for back cases.

Table 4 summarizes the results for nonhospitalized disabling injuries. Again, the differences in means and the regression results indicate that medical payments are lower in states with trauma care systems. The regression equations explain between 20% and 35% of the variation in medical payments for the different injury groups. The effect of trauma care systems is negative and significant at the 99% confidence level or higher. Other variables also have the expected effects. As indicated in **Table 5**, the savings average \$75 per case (10% of costs). For back sprains and strains, the savings are \$115 per case, compared with between \$35 and \$50 for the other injuries. Total annual savings are almost \$450 million, including \$300 million saved on back injuries.

SAVINGS IF TRAUMA CARE SYSTEMS WERE IMPLEMENTED NATIONWIDE

Estimated cost savings from nationwide implementation of state trauma care systems are presented in **Table 6**. Extending trauma care systems nationwide could lower annual medical care payments by \$3.2 billion (which includes \$1.8 billion in the body regions covered by our sample) and save \$7.1 billion in productivity losses from reduced fatalities. Total savings in 1988 dollars would be \$10.3 billion annually, which is 5.9% of national injury costs (from Rice et al¹¹).

The primary strengths of this analysis spring from the size and richness of the DCI data. They constitute a nationally representative, longitudinal sample of disabling workplace injuries. We also found that the results were robust with different specifications of the equations (including the addition of other potentially relevant variables and estimating equations for the most frequent injuries within categories—back sprain, upper-extremity fracture, upper-extremity laceration, and finger nonfracture).

Potential weaknesses of the analysis are the unknown ability to generalize to nonworker populations, the inability to consider certain types of injury (eg, head injuries), and the failure to consider some potential indirect effects of trauma care systems on costs.

To corroborate whether the DCI data are representative, we compared estimates on medical utilization and payments from DCI with other national estimates. The average acute-care stay for live DCI injury discharges was 6.2 days compared with 6.4 days from NHDS data for 1984 through 1986. Miller et al¹⁴ found that the payments per hospitalized motor vehicle crash injury estimated from DCI data were \$11 834 (in 1985 dollars) compared with a nationally representative estimate by Rice et al¹¹ of \$12 088 (based on length-of-stay data from the NHDS and cost data by injury category from the Maryland Cost Review Commission). For nonhospitalized crash injuries, Miller et al estimated payments of \$312 from DCI data compared with an estimate of \$308 by Rice et al (based primarily on data from the National Health Interview Survey and the National Medical Care Utilization and Expenditure Survey). The various estimates from DCI are quite close to those obtained from other nationally representative data sources.

The DCI database also samples from a major subset of all injuries. Adjusting Nelson's¹³ findings for growth in claims over time (assuming that the number of claims per 1000 covered workers was stable), we estimate that a total of 1.47 million claims were processed annually from 1984 through 1986. Since 30% of DCI lost workday claimants for traumatic injury are hospitalized, approximately 440 000 claims per year involve hospitalization. Using hospitalization data for 1984 through 1986 compiled by Rice et al¹¹ from the NHDS (with a supplemented back injury count), we find that the DCI data represent a subsample drawn from 16% of total injury hospitalizations and 24% of injury hospitalizations among civilians aged 15 through 64 years. These estimates may be slightly overstated because the NHDS excludes Veterans Affairs hospitals. To estimate the percentage of all injuries in the DCI sampling frame, we multiply estimated total worker injuries from National Health Interview Survey data by the percentage of workers covered by workers' compensation (from the Statistical Abstract [1991]). We find that 14% of all injuries to civilians and 21% of all injuries to civilians aged 15 through 64 years are covered.

While our results indicate that a statewide trauma care system reduces average costs per episode for both

hospitalized and nonhospitalized injuries, there may be countervailing effects if trauma care leads to more hospitalization (which is more costly than less-intensive treatment). Regression equations were estimated to examine the effect of trauma systems on the probability of hospitalization. The results (not reported here) indicate that average hospitalization probabilities are slightly lower for upper-extremity fractures and other injuries and for back sprains but are higher for lower-extremity injuries. These findings are weaker than the findings on cost savings; the regressions explained only 9% of the variation in hospitalization status and were insignificant for upper-extremity fractures. In addition, estimation problems prevented us from using the more appropriate logistic regression analysis. Nevertheless, the results, at a minimum, do not indicate an increased overall probability of hospitalization.

CONCLUSION

Sound trauma care systems clearly improve outcomes. They can save the health care system more than \$3 billion annually while saving lives. However, systems meeting the standards of the American College of Surgeons are rare.¹⁶ Where they exist, they are threatened by reimbursement disincentives.¹⁷ Funding systems development and adequately reimbursing costs will impose initial start-up costs but provide considerable savings in the long term.

This study was supported by grant R49/CCR303675-02 from the Centers for Disease Control and Prevention, Atlanta, Ga.

We are grateful for the assistance of the National Council on Compensation Insurance, New York, NY, Ellen MacKenzie, PhD, and Marcia Mabce, PhD, John Douglass, MA, and Nancy Pindus, MBA, at The Urban Institute developed the National Hospital Discharge Survey and National Health Interview Survey data used in this article.

Reprint requests to National Public Services Research Institute, Suite 220, 8201 Corporate Dr, Landover, MD 20785 (Dr Miller).

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Invited Commentary

A trauma care system is an organized approach to the acutely injured patient that provides personnel, facilities, and equipment on an emergency basis within a defined geographic region. Heretofore, the favorable impact of trauma care systems and the justification for their implementation were measured by reductions in mortality and morbidity compared with localities without such systems. While saving lives and returning injured people to their preinjury status makes sense economically, data supporting such financial savings are difficult to tease out.

Miller and Levy compare medical payments for groups of injured patients with non-life-threatening trauma: injuries to the upper and lower extremities and back in states with and without organized systems of trauma care. The results are encouraging.

Because the state of readiness required of a trauma system tends to drive up the cost of providing care, the reduction in medical payments at first appears unexpected. After all, the real financial impact of providing quality trauma care is to reduce mortality and morbidity and, by implication, long-term disability. Not only do the authors imply that long-term disability is reduced, their data suggest that this can be done more efficiently and at less cost where an organized system is functioning.

The principal purpose of a trauma system is to return a functioning patient to society. Miller and Levy confirm medical payment cost savings between 10% and 18% without looking at the profound societal savings likely from an earlier return to work and an enhanced tax base.

As a final comment, one might speculate about patient groups not included in this report—critically injured multisystem trauma patients, for whom trauma systems were developed in the first place. Unless lives saved equal lives disabled, the savings among patients with major trauma are likely even greater than Miller and Levy suggest.

Kimball I. Maull, MD
Maywood, Ill

EXHIBIT 3
DATE 3/21/95
HB. 591

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME STUART A REYNOLDS MD BILL NO. 591
ADDRESS HAVRE MT DATE 3-21-95
WHOM DO YOU REPRESENT? MT COMMITTEE ON TRAUMA & PAIN
SUPPORT ✓ OPPOSE AMEND

COMMENTS:

- 1- TRAUMA IS AN UNRECOGNIZED EPIDEMIC
- 2- TRAUMA KILLS OUR YOUTH
- 3- TRAUMA IS COSTLY
- 4- SYSTEMATIZED CARE CAN REDUCE
DEATH, DISABILITY & COST
- 5- SYSTEMS COST LESS THAN \$10 PER
CAPITA

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA - AN EPIDEMIC; A NEEDLESS TRAGEDY

- ✓ From ages 1 to 44, causes more death than all other causes combined
 - In 1992, there were 346 trauma deaths in this age group
 - In 1992, in this age group there were a total of 261 from all other causes including heart disease, AIDS and cancer
- ✓ In Montana (1992) there were 403 high impact injury deaths among all age groups
 - 174 (43%) of these were motor vehicle-related
- ✓ An organized state-wide trauma system could potentially prevent one to two deaths per week
- ✓ More than \$40 million in direct health care dollars spent in Montana each year.
- ✓ Montana has a high PREVENTABLE death rate - > 2.5 greater than a comparable area of Oregon with an organized trauma system
- ✓ The problem: MONTANA DOES NOT HAVE A TRAUMA SYSTEM

TRAUMA SYSTEMS SAVE LIVES!!

The information below shows, without question, that even the early development of a trauma system, in a rural area, improves the outcome of prehospital and hospital treatment, resulting in a lower percentage of preventable deaths. This doesn't even account for the effect of public education, prevention programs, and repeat training enhancement by medical personnel. This epidemic could be markedly curtailed by investing less than \$1.00 per capita in a system and grant program which allows us to improve care.

OREGON ATAB-7

Preventability for Hospital Deaths

<i>Combined Data (N=122)</i>		Oregon (n=46)		Montana (n=76)	
PREVENTABILITY		#	%	#	%
Frankly Preventable		3	7%	5	7%
Potentially Preventable		6	13%	19	25%
Total Preventable		9	20%	24	32%
Non-Preventable		37	80%	52	68%



DOT/NHTSA

EXHIBIT 4
DATE 3/21/95
HB 591

HOUSE OF REPRESENTATIVES

House Taxation COMMITTEE

WITNESS STATEMENT

PLEASE PRINT

NAME John Middleton M.D. BILL NO. HB 591

ADDRESS 1230 N. 30th St Billings DATE 3-21-95

WHOM DO YOU REPRESENT? Mont. Comm. on Trauma

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS: See attached

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA CARE IN MONTANA: WHAT ARE WE DOING ABOUT IT?

- ✓ High trauma death rate
 - Have learned about concept of preventable deaths
 - Completed preventable death studies in Montana
 - Trauma systems reduce preventable deaths
- ✓ State Trauma Task Force formed
 - Montana Trauma System Plan
 - Optimal use of existing resources
 - Facilitate rather than regulate
- ✓ Volunteer efforts have accomplished a great deal
 - Successfully competed for limited federal funding to begin the system
 - Regional Trauma Advisory Committees formed
 - Hospitals starting to form trauma teams and trauma committees
 - Hospitals (15) collecting Trauma Register Data
- ✓ Training with federal funding
 - EMT and First Responder
 - Trauma nurse training in rural areas

TRAUMA SYSTEMS SAVE LIVES!!

EXHIBIT 5
DATE 3/21/95
HB 591

HOUSE OF REPRESENTATIVES

House Taxation COMMITTEE

WITNESS STATEMENT

PLEASE PRINT

NAME Robert N. Hurd, M.D. BILL NO. 591

ADDRESS Billing Clinic Billings, MT DATE 3/21/95

WHOM DO YOU REPRESENT? Br 35100 59107-5700
Montana Committee on Taxation

SUPPORT X OPPOSE _____ AMEND _____

COMMENTS: see attached Testimony

**WRITTEN TESTIMONY - TRAUMA LEGISLATION,
HOUSE BILL #591; WHY HAVE IT?**

My dear representatives and fellow Montanans:

I come before you today to speak in favor of House Bill #591. My name is Dr. Robert Hurd. I am a general surgeon in Billings, Montana associated with the Deaconess/Billings Clinic Health System. I've been the Director of the Trauma Service for the last four years. I am a third generation Montanan, being born and raised in Sidney, Montana, and I returned to Montana to devote my career to the health and welfare of fellow Montanans like yourself.

My message is quite simple. A trauma system in this state supported by underlying legislation will save lives, return injured people to work faster after their accident, and finally, save money. This happens because trauma systems reduce the death rate, reduce the severity of injury and get people back on their feet and rehabilitated faster in any state that has a trauma system versus any state that does not have an organized trauma system and legislation. We could see 15% lower costs per hospitalization after an accident. This would save over \$1,000.00 per case. Montana already has dedicated medical professionals and institutions. We have hard working caregivers, and unselfish volunteers who run the majority of our ambulance services. All of us need legislative help to further our efforts.

Why should the state of Montana become involved and pass House Bill #591 during this legislative session? Although many improvements can be made at the local level, a system of care, even a voluntary system, requires a coordinated state-wide and regional approach. This bill establishes a trauma care system and provides some rule-making authority. Although our system is a voluntary one,

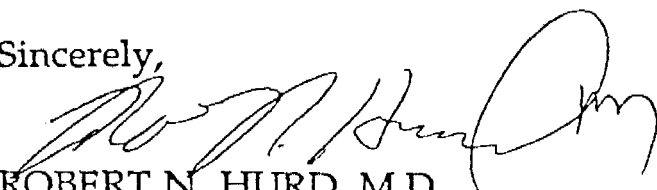
rule-making authority is essential if we want to improve our care. This authority will come through regional trauma committees, a state trauma committee and a state Emergency Medical Systems Advisory Council. These committees, composed of interested participating caregivers from all over the state, will provide the core for our state trauma system. House Bill #591 will allow the EMS department to classify or designate hospitals according to their varying capabilities and resources to manage the trauma patient. The bill does not mandate hospitals participate, but rather encourages them to do so. House Bill #591 will also allow for changes in how trauma care is delivered in Montana on the basis of the collection and analysis of reliable data. We need an honest review and evaluation of these data. House Bill #591 will also provide legal safeguards needed to protect peer review data for all of our fellow caregivers at the on a regional basis. Safeguards designed to assure honesty and candor in reviewing trauma data is essential and can only be done through legislation. House Bill #591 also provides a dedicated funding source for motor vehicle registration to establish a grant-in-aid program on a matching-funds basis to assist local ambulance services, most of which are volunteer, and also medical facilities to help them achieve their goals of becoming better trauma caregivers. We know that trauma systems will also serve as a good model for regionalized health care delivery systems in all of Emergency Medical Services.

In summary, House Bill #591 will allow us to integrate the resources of caregivers, ambulances, communications, hospital care, triage and transport to make sure that our Montanans who are injured on the road or at the job site will be cared for at the right place, at the right time, under the right conditions, with good results. Trauma system development is a team effort. If the legislature delivers the framework through House Bill #591 we health care professionals will do our part to reduce Montana's needless tragedies. Please help us in this

endeavor. This will be a good investment which will return both lives and money to our state.

Thank you very much!

Sincerely,

A handwritten signature in black ink, appearing to read "Robert N. Hurd", with a stylized flourish at the end.

ROBERT N. HURD, M.D.

lp

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA LEGISLATION: WHY HAVE IT?

- ✓ Formal advisory structure - uses data and Quality Improvement
 - Regional Trauma Advisory Committees (RTAC)
 - State Trauma Committee
 - State EMS Advisory Council
- ✓ Authority to Department to implement a state-wide trauma system and adopt rules
 - Voluntary system
 - Inclusive system
- ✓ Designation of hospitals as various levels of trauma facilities
- ✓ Hospital and System Trauma Register
 - Used for Quality Improvement - local, regional and state
 - System improvements
 - Confidentiality of Quality Improvement/Peer Review Data
 - "Targeting" prevention programs
- ✓ Motor vehicle registration fee
 - Most of funding for grants, on matching funds basis, to local ambulance services, Quick Response Units and medical facilities.
 - Funds for state-wide coordination, training, technical assistance, data collection
- ✓ Trauma systems - a model for health care delivery

TRAUMA SYSTEMS SAVE LIVES!!



**Montana
Deaconess**

Medical Center

1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

EXHIBIT 6
DATE 3/21/95
HB 591

Chairman Hibbard & Members of the Taxation Committee:

My name is Susan O'Leary and I represent the Trauma Coordinators throughout Montana. I have worked as an Emergency Department Nurse for 15 years, and am currently employed by Montana Deaconess Medical Center in Great Falls as a Trauma Coordinator. Those of us employed as Trauma Coordinators have first hand knowledge of what systematized trauma care can provide within our facilities for the trauma patient, yet we have been unable to orchestrate a system outside of our facilities because we lack a state-wide trauma plan.

I come before you this morning to share why we need a trauma system in our state what it is and what it can do to improve trauma care, as well as decrease the mortality and disability associated with trauma.

As we in business and government are called upon to do more with fewer resources, systems planning has been a prevalent response. A trauma system is an organized, pre-planned response to care for a trauma patient. This planning must not be restricted to local planning, but must also include planning on a regional and statewide basis. With appropriate planning we can assure that the patient will receive good care at the scene of the accident as well as a rapid transfer to the appropriate medical facility best capable of managing their injuries.

In practical terms, what will the Trauma System provide?

There will be rapid response of well trained EMT's and First Responders for the trauma victim via 9-1-1. These prehospital personnel will be trained to recognize the severely traumatized patient and will provide rapid treatment and early notification of the local hospital or medical assistance facility.

Because of early notification of an incoming trauma patient, the receiving facility will be able to assemble a trauma team of physicians, nurses, and other personnel necessary to provide prompt, excellent care to the patient. This system will rely heavily on the local surgeons because early surgery is often the key to survival.

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

WHY HAVE A MONTANA TRAUMA SYSTEM; WHAT IS IT?

- ✓ Organized , preplanned response to trauma patient - locally, regionally & statewide
- ✓ Rapid response, via 9-1-1, by ambulance services (air & ground). They recognize major trauma patient and communicate to medical facility
- ✓ Medical facility has trauma team (physician, nurse, operating room, etc) ready when patient arrives at their door. This depends of resources of the community.
- ✓ Early surgery often the key to survival
- ✓ If patient's condition exceeds capability of medical facility, Central Medical Resource will quickly coordinate all transportation and transfer arrangements.
- ✓ Match the right patient with the right medical facility in the right amount of time. Time is critically important X
- ✓ Initiate rehabilitation as soon as possible. Return patient to home community as soon as practical
- ✓ Continual improvements to system by good data and candid critique. RTACs evaluate regional responses and help to make it better
- ✓ PREVENTION is a major part of trauma system at local, regional and state

TRAUMA SYSTEMS SAVE LIVES!!



EXHIBIT 7
DATE 3/21/95
HB 591

MONTANA NURSES' ASSOCIATION

104 BROADWAY, SUITE G-2 • HELENA, MONTANA 59601 • PHONE 406-442-6710

Chairman Hibbard and Members of Taxation Committee,

My name is Sharon Diezger and I represent the Montana Nurses' Association. I'm also a member of the Statewide Trauma Task Force.

I'm speaking in support of House Bill 591. Every day in Montana's Emergency Rooms we are faced with the devastating news that a trauma patient is enroute from somewhere. The long distances and wide open spaces that we enjoy present a real challenge to us when a citizen of Montana becomes a trauma victim. It is not entirely unusual to have them arrive in the back of a pick-up truck. We need to be able to prepare and educate even our smallest and most isolated communities on what to do and how to safely transport. Trauma does not just occur in the cities.

In Montana we are usually faced with blunt trauma vs penetrating trauma - only because right now we don't have as many knife and gun clubs as other states. However, blunt trauma can be just as devastating, and just as debilitating.

To save you time, I am attaching specific information regarding the intent of the bill which explains the Trauma Register, Quality Improvement and Legal Protection aspects that are so essential to make a system like this work.

The plan you have before you represents the state's battle plan in the war against trauma. The Montana Trauma System organizes, integrates and refines existing health care resources throughout the state to provide improved care of injured patients. Saving lives and saving money are certainly worthwhile goals for the State of Montana to consider. An affirmative vote for House Bill 591 is vital. It will make a difference.

Thank you for your time.

ATTACHED INFORMATION

TRAUMA REGISTER, QUALITY IMPROVEMENT, LEGAL PROTECTION

Montana's trauma system is based on having good data which drives quality improvement. What does this mean? It puts a lot of faith in our interest in providing good care to all patients and to do the right thing. We are up to that challenge.

Quality Improvement is a process by which we health care providers establish reasonable goals or standards designed to improve patient care. by collecting good data, we can determine if we are meeting those goals. If we aren't, we must figure out together where the problems lie and how we can fix them.

Quality improvement is dependent upon health care providers honestly sharing information with each other, candidly visiting about the problems and jointly arriving at solutions. The whole system must be non-punitive. If the quality improvement information can be legally discovered or publicly released, the incentive for honest and candor in making improvements is substantially reduced.

In the Montana Trauma System, data is collected and reviewed at several levels. In the Hospital Trauma Register, supplied by the EMS Bureau, we collect information about seriously injured patients. This data is used by our in-hospital trauma committee to evaluate our trauma program and to make assist in making improvement. We also supply a portion of these data to the State EMS Bureau for the State Trauma Register.

The EMS Bureau provides quality improvement type regional data to the Regional Trauma Advisory Committees. By reviewing this data and comparing it to standards of care, the RTAC will work with hospitals and emergency medical services to make improvements. They will help identify and "fix" problems on a voluntary basis by providing education and technical assistance without fear of legal jeopardy. They will also make changes in the regional system of trauma care so it works more smoothly.

State-wide quality improvement data will be provided to the State Trauma Committee which will review statewide data and work with regions and individual services to make improvement. They will assess and act on statewide data and use the data for future system improvements.

Recognizing the importance of the candor and honesty afforded by quality improvement, the legislature has previously provided "peer review" legal protections to in-hospital committees. House Bill 591 provides the same legal protections to the Regional Trauma Advisory Committees, the State Trauma Committee and the Department. Their ability to use data for quality improvement is essential to the operation of the Montana Trauma System.

Only individual patient care data or reports used for quality improvement are protected. General information not identified by facility and not used for quality improvement are not protected and are considered as public information.

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

QUALITY IMPROVEMENT - THE BASIS OF THE TRAUMA SYSTEM

- ✓ Use of data to evaluate how well we are doing and to make improvements when needed
- ✓ Health care professionals must honestly discuss the trauma data and figure out solutions
 - To be successful, it must be done without fear of legal discovery
 - "Fix" problems by education and training - not punishment
- ✓ Hospital and system trauma registries are our data collection tools
 - Used by hospitals, Regional Trauma Advisory Committees, and state EMS
 - HB 591 provides legal protection to the Quality Improvement portion of the data
 - Original patient records are still discoverable

TRAUMA SYSTEMS SAVE LIVES!!

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA SYSTEM FUNDING:

- ✓ Trauma is a costly public health problem
- ✓ Direct medical costs of trauma exceed \$40 million per year
- ✓ Assessment on motor vehicle registration
 - \$.90 the first year
 - \$1.20 the second year
- ✓ Why motor vehicle registration?
 - Nearly 50% of trauma deaths are motor-vehicle related
 - Many of serious trauma injuries
- ✓ Grant-in-aid program to ambulance services, quick response units and medical facilities
 - More than 50% of funds for this purpose
 - Matching funds required
 - Help bring up to standards
 - Help with education and equipment
- ✓ State trauma system coordination and assistance
 - Training and technical assistance
 - Data collection and quality improvement
 - Prevention
 - Trauma nurse coordinator & clerical person

TRAUMA SYSTEMS SAVE LIVES!!!

DATE 3/21/95
HB 591

EXHIBIT 98
DATE 3/21/95
HB 591

HOUSE OF REPRESENTATIVES

House TAXATION COMMITTEE

WITNESS STATEMENT

PLEASE PRINT

NAME Mrs D. SANDOZ BILL NO. 591
ADDRESS 317 N. 2ND, LIVINGSTON DATE 03/21/95
WHOM DO YOU REPRESENT? CRITICAL ILLNESS AND TRAUMA FOUNDATION INC.
SUPPORT ✓ OPPOSE _____ AMEND _____
COMMENTS: SEE ATTACHED TESTIMONY

A MONTANA TRAUMA SYSTEM - A NECESSITY, NOT A LUXURY

TESTIMONY IN SUPPORT OF HB 591

Nels D. Sanddal, President and CEO
Critical Illness and Trauma Foundation, Inc.
301 West First Avenue, P.O. Box 1249
Big Timber MT 59011

My colleagues' testimony has painted a very clear picture. Trauma is a major public health problem in Montana. Trauma claims more lives for Montanans between the age of 1 and 44 than all other causes of death combined. Trauma is a costly health care issue both in terms of direct medical costs and the ongoing erosion of Montana's taxable income base. What makes this tragedy even more devastating is that so many of these deaths could be averted with a state-wide trauma system.

During the past few years, Montana's health care professionals have dedicated countless thousands of hours of time; a wealth of creative energy; and a portion of their limited personal and institutional resources to the planning and early implementation of a voluntary, state-wide trauma system. As is clearly demonstrated by the research on preventable trauma mortality, Montana's health care providers are willing to critically and objectively analyze current shortcomings in an effort to improve future responses. They have done so because research has proven that a trauma system can save many lives.

House Bill 591 provides the framework for the planning, implementation, provider input and ongoing improvement of a comprehensive and integrated system of trauma care. It establishes a voluntary structure that is data-driven and where problems can be discussed and improvements made without undue concerns about legal repercussions. It provides the resources necessary for coordination, professional education and technical assistance. Based on needs identified by front-line care providers, it also provides for grant support to local areas for equipment, training and other needs.

We desperately need the state and regional coordination, education, technical assistance and legal safeguards that the proposed Montana Trauma System provides. This is not a top-heavy bureaucratic program. Having worked for several years as a state employee I am well aware of the shortcomings of over-regulation. The Montana Trauma System is a streamlined and voluntary system which has been carefully planned by the medical community to best care for injured friends, neighbors and loved ones in their hour of greatest need.

Based on my 20 years of experience in attempting to improve outcomes for trauma patients as a volunteer EMT, elected association officer, state health official and foundation executive, and on behalf of the Critical Illness and Trauma Foundation, I urge your strong support of HB 591. Each of my colleagues assembled here, as well as hundreds more who can not be with us today, have all had a part in planning the Montana Trauma System. We now need your support and help to make the Montana Trauma System a reality and to prevent the daily recurrence of Montana's needless tragedy... the unnecessary death of our youth.

Thank you for your attention and for your support of HB 591.

EXHIBIT 10
DATE 3/21/95
HB. 591

21 March 1995

Mr. Chairman,

My name is Paul Donaldson, and I have been a board certified Family Physician practicing in Helena for the past 20 years. I would like to speak today in support of House Bill 501, *Montana's Trauma System Legislation.* *I would like to address the physician education component of this system.*

One year ago I took the Advanced Trauma Life Support course for physicians in Bozeman to update my trauma skills. This course is supported by this legislation. I found this course to be rigorous, challenging, well organized, and a whole new approach to the management of trauma (compared to the trauma education I received in medical school 20 years ago). ~~Prior to this course I had no idea how outdated my trauma management skills were.~~ I am quite certain that haven taken this course, I will be better able to help my future trauma patients, and I will be a more useful component of our state's trauma support system.

Considering how much has changed in trauma management in the past several years, and that the average age of Montanas physicians is 42 (only a couple of years younger than I), I suspect that most of my colleagues need this education as much as I did.

I would urge your support of this legislation to help your physicians keep up to date to better serve you.

Thank you.

EXHIBIT 11
DATE 3/21/95
HB 591

TESTIMONY OF TIM BERGSTROM

HOUSE BILL 591

The Montana State Firemens' Association is in strong support of House Bill 591.

An effective statewide trauma system is truly in the best interest of all Montanans.

Calls for emergency medical assistance have taken over as the most predominant calls for fire department assistance in Montana's municipalities.

Where fire fighters formerly responded on an occasional fire and performed business inspections to insure safety of the public, their roll has changed significantly.

We now respond with great frequency to victims of assault, suicide attempts, gunshot wounds, stab wounds, heart attacks, strokes, and vehicular accidents.

As a result, fire fighters have aggressively upgraded their emergency medical skills. EMT's are the norm in Montana fire departments, and many have enrolled in paramedic programs; while others have already been certified as paramedics.

You've heard the benefits of a statewide trauma system; how such a system will certainly aid in saving more lives.

I'd like to give the committee some figures from 1994 that were provided by five of Montana's major cities relative to the frequency of emergency medical calls for fire department assistance.

Missoula -	3,211 total calls	
	1,834 were EMS	59%
Bozeman -	842 total calls	
	500 were EMS	60%
Gt Falls -	3,541 total calls	
	2,377 were EMS	67%
Helena -	1,769 total calls	
	1,210 were EMS	68%
Billings -	5,959 total calls	
	4,237 were EMS	71%

I think these figures demonstrate the need for a statewide trauma system.

We support the creation of a statewide Trauma Council as provided for in the bill, and would take an active part in the Council's efforts to identify critical issues in the application of a statewide trauma plan.

Fire fighters can be a major participant in "prevention" related trauma education as well, and look forward to

trauma system that will enhance the

Attacking trauma's death toll

Montana needs coordination
to improve injury care

MONTANA TRAUMA CARE has been compared to a crapshoot.

How well a seriously injured patient is cared for may depend a lot on where he is when injured, the time of day and who among Montana's thinly-stretched rural medical providers is available then.

The gambling analogy comes from doctors, nurses and other emergency medical services providers in the system. For nearly three years, a statewide trauma task force, working with the Emergency Medical Services Bureau in Helena has been looking at care and where it can break down. The task force recommendations have produced HB 591, introduced by Rep. Bill Wiseman, R-Great Falls, and co-sponsored by 10 other legislators from both parties and all over the state.

Injury is the leading cause of death for Montanans ages 1 to 44, and motor vehicle wrecks are the leading cause of trauma, claiming 210 lives in Montana last year.

Recent scientific studies have shown that a trauma system can save lives and reduce disability from injury in rural and urban areas. A study of Montana trauma cases concluded that one in four deaths from traumatic injury could have been prevented with optimum care.

The EMS professionals and the sponsors of HB 591 aren't seeking high technology. They aren't planning to put a trauma surgeon in every small hospital. Instead, the system would allow providers to coordinate care and make the best use of the resources we have. Cost-effective education would be available for updating skills of rural ambulance volunteers as well as hospital trauma teams. A key component would be review of trauma cases for lessons that could be learned and shared. Each health care facility could be part of the system and would have a voice in the system.

If the plan would save lives and has geographically diverse, bipartisan support, it would seem a popular measure for the Legislature to approve. But there's still the matter of paying for it. HB 591 includes a funding proposal: a 90-cent assessment for every vehicle registered in 1996 and \$1.20 per vehicle in 1997. The proceeds, about \$800,000, would be used mostly for grants to local health care providers. Two state employees would be hired.

Funding a trauma system with a motor vehicle fee is logical; most serious trauma results from traffic wrecks. Think of the \$1.20 as an insurance policy, improving the odds that you and your loved ones will get good care. We believe it will be money well spent.

HB 591 is scheduled for a hearing at 8 a.m. Tuesday before the House Taxation Committee.

EXHIBIT 12
DATE 3/21/95
HB 591

*Billings
Gazette
3-20-95*



Montana Emergency Medical Services Association

P.O. Box 236
Roy, MT 59471
(800) 247-2369

EXHIBIT 13
DATE 3/21/95
HB 591

DATE: March 20, 1995

TO: House Taxation Committee
Chase Hibbard, Chair
Committee Members

SUBJECT: Testimony Concerning HB591, Statewide Trauma
Care System

The Montana Emergency Medical Services Association Inc. (MEMSA) is the professional organization of pre-hospital care providers in our state. The majority of our members are associated with rural volunteer emergency medical service (EMS) entities. MEMSA members reside in over 40 of Montana's counties.

The effects of a statewide trauma care system will be improved education, communications, coordination and cooperation for all members of the patient care team. The end result being that fewer of our friends and neighbors will die as a result of trauma and the effects of the trauma will be mitigated for those who are injured.

Montana, being a rural, sparsely populated state, depends on volunteer emergency medical services organizations to assure that EMS is available when needed. These organizations strive to provide high quality and efficient service for their friends, neighbors, and others with very limited resources. The grants in aid program is not intended and will not alleviate the shortage of resources. It will however provide assistance in areas where data demonstrates a direct effect on patient outcome is possible.

At the 1994 meeting of the MEMSA membership a resolution in support of the statewide trauma system was introduced and endorsed by a large majority of the members. (Attached)

MEMSA strongly supports this bill and urges you as a committee to give it a "DO PASS" recommendation.

Sincerely;


John Gervais
President



RESOLUTION ON TRAUMA SYSTEM AND TRAUMA SYSTEM LEGISLATION

Whereas, trauma is the leading cause of death and disability in children and young adults; and

Whereas, trauma is a significant problem in the state of Montana; and

Whereas, other areas have demonstrated that an organized system for trauma care will reduce death and disability; and

Whereas, reducing death and disability from trauma will reduce medical costs; and

Whereas, the Montana Trauma System Plan will provide for input and representation by pre-hospital care providers; and

Whereas, data collection will provide information on how prevention and care of trauma patients can be improved; and

Whereas, communications between all levels of care providers will be improved by the trauma system; and

Whereas, a trauma system will promote and/or provide specialized training for all providers; and

Whereas, a systematic approach to trauma care will improve consistency of care and operations; and

Whereas, the trauma system will provide limited funding to improve trauma prevention and care at all levels; and

Whereas, an objective of the Montana Emergency Medical Services Association is to reduce trauma and promote quality care; and

Now, therefore, the Montana Emergency Medical Services Association hereby resolves to support the Montana Trauma System Plan and legislation designed to implement the plan.

EXHIBIT 14
DATE 3/21/95
HB 591

-----VEHICLE INFORMATION-----
TYP YR MAKE MODL STYL COLOR VIN
PC 94 DODG INT 4D GRN 1B3ED46T2RF146429
EXP DATE 10/31/94 TITLE NO W741096
PLATE NO BUYACAR FLT TYPE FE TAB NO R676582
FUEL TYPE 1 EQUIP NO UNLADEN WGT 03181 TON 000

MONTANA AUTO DEALERS ASSOC
510 N SANDERS
HELENA MT 59601

-----FEE INFORMATION-----
02 NEWUSE \$ 280.51 12 REGFEE \$ 5.00 13 LICFEE \$ 10.00
16 TTLCO \$ 1.50 17 JUNK \$ 0.50 18 WEED \$ 1.50
19 HPFUND \$ 0.25 24 JNKTTL \$ 1.50 29 COPE \$ 5.00
32 TTLST \$ 3.50 34 PERENW \$ 5.00 42 SYSFEE \$ 1.00
38 PETRAN \$ 5.00

-----COUNTY INFORMATION-----
TRAD VAL 18700.55 CO 05 SDHL 1 F01 PRORATE 12/12
MRKT VAL MILL 418.160 FCC 4101 TREAS DEF 04
TAX VAL ASSD DATE 11/09/93 ASSD BY

UNLAWFUL TO OPERATE VEH W/OUT VALID VEH LIABILITY INSURANCE
POLICY, CERTIFICATE OF SELF-INSURANCE, OR POSTED INDEMNITY
BOND, AS REQUIRED BY 61-6-301, UNLESS EXEMPT BY 61-6-303.

BY REGISTERING THIS VEHICLE THE APPLICANT ACKNOWLEDGES
HAVING KNOWLEDGE OF THE FMCSR AND FHMR, IF APPLICABLE.

ASSESSMENT INFORMATION:
MARKET VAL: _____ TAXABLE VAL: _____ TRADE VAL: _____
MILL LEVY: _____ COUNTY TAX: _____ FACTORY PRICE: _____
DATE VALUED: _____ VALUED BY: _____ OPID 0504

STATE \$ 303.76 COUNTY \$ 16.50 TOTAL AMT \$ 320.26
ORIGINAL - OWNER FILE/1 COPY - OWNER

CK#3707

EXHIBIT 15
DATE 3-21-95
HB 591

Amendments to House Bill No. 591
First Reading Copy

Requested by Rep. Wiseman
For the Committee on Taxation

Prepared by David S. Niss
March 10, 1995

1. Title, line 12.

Strike: "PROVIDING AN APPROPRIATION;"

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Laxation COMMITTEE BILL NO. HB 591
 DATE 3/21 SPONSOR(S) Rep. Wiseman

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tharm Dieziger	MT Nurses Assoc	591		✓
Gary Haigh	MT EMS Assoc	591		✓
John Garwood	MT EMS Assoc	591		✓
Susan O'Leary	Montana Trauma Nurses	591		✓
Carole Kellogg		591		✓
Hugh Kellogg		591		✓
Robert Dieziger		591		✓
SNARE REYNOLDS MD	MT COMMITTEE ON TRAUMA	591		✓
JOHN MIDDLETON MD	MT COMM. ON TRAUMA	591		✓
Draw Dawson	Dept Health	591		✓
PAUL DONALDSON		591		✓
Jim DeHenne	Dept Health			✓
JAMES A. LOFFTUS	MT FIRE DIS ASTN	591		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Robert M. Hurd, MD
 Apollo Medical

MT Committee
 C. R. Foundation

591
 591

✓
 ✓

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

TAXATION COMMITTEE BILL NO. HB 591
 DATE 21 MAR 95 SPONSOR(S) Rep Wiseman

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUB
ART BICSAK Box 1831 GF 59403	CASCADE COUNTY EMS COUNCIL			✓
Steven Shapiro	MT Nurses Ass	591		✓
Tim BERGSTROM	MT State Firemen's Assoc.	591		
Steve Turkiewicz	Mt. Auto Dealers Assn	591	✓	
Steve Yeakel	MT Council for Maternal & Child Health	591		✓
	Mt. Med. Assoc.	591		✓
Bob Olsen	MT Hospital Assoc.	591		✓
Jill Z Smith - McGuire	ABATE OF MT	161		✓
Coila McDonnell	ABATE OF MT	161		✓
RN MS Lunn	ABAT OF MT	161		✓
Jennie Nemes	St. Peter's Community Hosp.	591		✓
TOM EBZERY	St Vincent Hospital & Health Care	591		✓
CHRIS BAILEY	ABATE OF HELENA	161		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
 ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Alice Hansen

MLC+

✓

{Tape: 1; Side: A.}

EXECUTIVE ACTION ON HB 591

Motion:

REP. ELLIOTT MOVED HB 591 DO PASS.

Discussion:

REP. ELLIOTT said the bill was a worthy one, but it would earmark funds which he opposes. Therefore, he proposed an amendment to the bill which would strike the fee on license plates and appropriate money from the general fund. EXHIBIT 1.

Motion/Vote:

REP. ELLIOTT MOVED THE AMENDMENT.

Discussion:

REP. ORR said the amendment was a good one and the general fund would provide proper funding.

REP. SOMERVILLE, REP. WENNEMAR and REP. FUCHS all spoke in favor of the amendment.

Vote:

On a voice vote, the motion passed unanimously.

Motion:

REP. ELLIOTT MOVED THAT HB 591 AS AMENDED DO PASS.

Discussion:

REP. ORR said he reluctantly opposed the bill because the hospital in his district would not be able to meet the requirements to set up committees with certain qualifications because they are not available in rural hospitals. There are good parts to the bill as far as education is concerned.

REP. STORY said his concerns with the bill were the same as Rep. Orr's. It would be good to have goals but some of the hospitals in rural areas would not be able to meet the rules and regulations. It would be difficult to find people to staff the volunteer services because of the time involved in training in order to meet the standards. There is also an equipment problem. He said he also had a problem with the confidentiality aspect of the bill.

REP. RYAN said he would speak highly in favor of the bill. He said the volunteers from rural Montana came to the hearing asking for training, organization, and regulation. This would improve the system throughout the state.

REP. NELSON said he thought the system could be put together outside of a governmental structure.

REP. RYAN said the bill would allow them that freedom but they need help and guidance in putting together an organization statewide.

REP. STORY said he thought they had that organization -- the Montana Emergency Medical Services.

REP. ROSE said he wondered if the bill would put pressure on the smaller hospitals to meet stricter requirements, or add administrative levels for trauma care.

REP. RANEY commented that bill would provide for a new program and the cost would be \$2 million per biennium.

REP. REAM said he had discussed the bill with the proponents after the meeting and they had indicated they would like to have the bill passed even if there were no appropriation in it. The bill has real value for formalizing the structure of the program. There would be a committee appointed by the Governor which would lend credibility. One of the main portions of the bill is the strategic plan for trauma care.

REP. MURDOCK said she would concur with Rep. Ryan's comments.

Vote:

On a roll call vote, the motion passed, 11 - 8.

EXECUTIVE ACTION ON HB 589

Motion:

REP. STORY MOVED THAT HB 589 DO NOT PASS.

Discussion:

REP. HARPER explained that the Elks organization pays \$16,000 a year rent to the federal government and the government pays a fee in lieu of taxes from that amount to local governments. In effect, if this bill is not passed, the Elks Club will have another tax that other people don't pay.

REP. WELLS said he understood that at one time they did not have to pay the tax and, as a result of some law changes, they were

HOUSE OF REPRESENTATIVES

Taxation

ROLL CALL

DATE 3/23/95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Chase Hibbard, Chairman	✓		
Rep. Marian Hanson, Vice Chairman, Majority	✓		
Rep. Bob Ream, Vice Chairman, Minority	✓		
Rep. Peggy Arnott	✓		
Rep. John Bohlinger		by	✓
Rep. Jim Elliott	✓		
Rep. Daniel Fuchs	✓		
Rep. Hal Harper	✓		
Rep. Rick Jore	✓		
Rep. Judy Rice Murdock	✓		
Rep. Tom Nelson	✓		
Rep. Scott Orr	✓		
Rep. Bob Raney	✓		
Rep. Sam Rose	✓		
Rep. Bill Ryan	✓		
Rep. Roger Somerville	✓		
Rep. Robert Story	✓		
Rep. Emily Swanson	✓		
Rep. Jack Wells	✓		
Rep. Ken Wennemar	✓		



HOUSE STANDING COMMITTEE REPORT

March 23, 1995

Page 1 of 2

Mr. Speaker: We, the committee on Taxation report that House Bill 591 (first reading copy -- white) do pass as amended.

Signed: _____

A handwritten signature in cursive script, appearing to read "Chase Hibbard", is written over a horizontal line.

Chase Hibbard, Chair

And, that such amendments read:

1. Title, line 11.

Strike: "IMPOSING A FEE ON CERTAIN VEHICLES;"

2. Title, line 12.

Strike: "SECTIONS"

Insert: "SECTION"

Strike: "61-3-321, AND 61-3-510,"

3. Page 4, line 12.

Page 6, line 20.

Page 6, line 21.

Page 10, line 13.

Page 14, line 8.

Page 14, line 9.

Strike: "12"

Insert: "11"

4. Page 10, lines 27 and 28.

Strike: "from" on line 27 through "12]." on line 28

5. Page 11, lines 1 through 20.

Strike: section 12 in its entirety

Renumber: subsequent sections

6. Page 12, line 1.

Strike: "12"

Committee Vote:

Yes 11, No 2.

671224SC.Hbk

March 23, 1995

Page 2 of 2

Insert: "11"

7. Page 12, line 3 through page 14 line 3.

Strike: sections 14 and 15 in their entirety

Insert: "NEW SECTION. Section 13. Appropriation. There is appropriated to the department of health and environmental sciences from the general fund \$366,162 for the fiscal year ending June 30, 1996, and \$854,379 for the fiscal year ending June 30, 1997, to implement [sections 1 through 11]."

Renumber: subsequent sections

8. Page 14, line 11.

Strike: "16"

Insert: "14"

9. Page 14, line 13.

Following: "10,"

Insert: "and"

Strike: ", and 13"

10. Page 15, line 15.

Strike: subsection (3) in its entirety

Renumber: subsequent sections

-END-

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

DATE 3/23/95 BILL NO. HB 591 NUMBER

MOTION: do pass as amended

NAME	YES	NO
Vice Chairman Marian Hanson		✓
Vice Chairman Bob Ream	✓	
Rep. Peggy Arnott		✓
Rep. John Bohlinger		
Rep. Jim Elliott	✓	
Rep. Daniel Fuchs	✓	
Rep. Hal Harper	✓	
Rep. Rick Jore		✓
Rep. Judy Rice Murdock	✓	
Rep. Tom Nelson	✓	
Rep. Scott Orr		✓
Rep. Bob Raney		✓
Rep. Sam Rose	✓	
Rep. Bill Ryan	✓	
Rep. Roger Somerville	✓	
Rep. Robert Story		✓
Rep. Emily Swanson	✓	
Rep. Jack Wells		✓
Rep. Ken Wennemar		✓
Chairman Chase Hibbard	✓	

EXHIBIT 1
DATE 3/23/95
HB 591

Amendments to House Bill No. 591
First Reading Copy

Requested by Rep. Elliott
For the Committee on Taxation

Prepared by Lee Heiman
March 21, 1995

1. Title, line 11.
Strike: "IMPOSING A FEE ON CERTAIN VEHICLES;"
2. Title, line 12.
Strike: "SECTIONS"
Insert: "SECTION"
Strike: "61-3-321, AND 61-3-510,"
3. Page 4, line 12.
Page 6, line 20.
Page 6, line 21.
Page 10, line 13.
Page 14, line 8.
Page 14, line 9.
Strike: "12"
Insert: "11"
4. Page 10, lines 27 and 28.
Strike: "from" on line 27 through "12]." on line 28
5. Page 11, lines 1 through 20.
Strike: section 12 in its entirety
Renumber: subsequent sections
6. Page 12, line 1.
Strike: "12"
Insert: "11"
7. Page 12, line 3 through page 14 line 3.
Strike: sections 14 and 15 in their entirety
Insert: "NEW SECTION. Section 13. Appropriation. There is appropriated to the department of health and environmental sciences from the general fund \$366,162 for the fiscal year ending June 30, 1996, and \$854,379 for the fiscal year ending June 30, 1997, to implement [sections 1 through 11]."
Renumber: subsequent sections
8. Page 14, line 11.
Strike: "16"
Insert: "14"
9. Page 14, line 13.
Following: "10,"
Insert: "and"
Strike: ", and 13"

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON TAXATION

Call to Order: By CHAIRMAN GERRY DEVLIN, on April 5, 1995, at
8:00 a.m.

ROLL CALL

Members Present:

Sen. Gerry Devlin, Chairman (R)
Sen. Mike Foster, Vice Chairman (R)
Sen. Mack Cole (R)
Sen. Delwyn Gage (R)
Sen. Lorents Grosfield (R)
Sen. John G. Harp (R)
Sen. Dorothy Eck (D)
Sen. Barry "Spook" Stang (D)
Sen. Fred R. Van Valkenburg (D)

Members Excused: None

Members Absent: None

Staff Present: Jeff Martin, Legislative Council
Renée Podell, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 363, HB 591
Executive Action: HB 598, HB 565, HB 524, HB 591

HEARING ON HB 591

Opening Statement by Sponsor:

REP. BILL WISEMAN, HD 41, Malmstrom, presented handouts for HB 591. EXHIBIT 1 AND 2. He explained the fiscal note is meaningless because the House took the money out. He gave an example of a trauma accident. REP. WISEMAN said this bill puts together structure so the people who are the first responders on an accident are equipped and trained to get the trauma victim to the hospital as quickly as they can.

Proponents' Testimony:

Stuart Reynolds, M.D., submitted an outline of testimony and discussed trauma as a needless tragedy. EXHIBIT 3.

John Middleton, M.D., presented an outline of testimony on trauma care in Montana. EXHIBIT 4.

Robert Hurd, M.D., presented written testimony. EXHIBIT 5.

Susan O'Leary, Trauma Coordinators throughout Montana, submitted written testimony. EXHIBIT 6.

Gloria Paladichuk, Richland Development, spoke in support of this legislation.

Sharon Dieziger, Montana Nurses' Association, Member of the Statewide Trauma Task Force, presented written testimony. EXHIBIT 7.

Gary Haigh, Hospital Care Provider, Montana Emergency Medical Services Association, submitted written testimony. EXHIBIT 8.

John Gervais, President, Montana Emergency Medical Services Association, presented written testimony. EXHIBIT 9.

Joe Hansen, EMT, strongly urged support for HB 591.

Charles Rinber, M.D., Montana Committee on Trauma, stated Montana has a serious problem with trauma care and urged passage of this bill.

Jim DeTienne, Montana Department of Health, urged support for this bill.

Tim Bergstrom, Montana State Firemen Association, stated increased care is needed for trauma cases and urged support for HB 591.

Dana Lovitt, Montana Medical Association, urged support for this legislation.

Steve Yeakel, Montana Council for Maternal and Child Health, presented written testimony. EXHIBIT 10.

Bob Robinson, speaking on behalf of Governor, urged support for HB 591.

Adele Borchardt, R.N., Columbus Hospital Trauma Coordinator, and Brian Christensen, R.N., Columbus Hospital Emergency Department Supervisor, presented written testimony. EXHIBIT 11.

Opponents' Testimony:

Russell Hill, Montana Trial Lawyers Association, stated the association is not opposed to the general concept of the bill or most of the bill, however, he said Section 10 of the bill in regard to confidentiality is being opposed to. Mr. Hill

acknowledged this provision is not consumer friendly. He highlighted problem areas in the bill.

Informational Testimony:

None

Questions From Committee Members and Responses:

SEN. DELWYN GAGE questioned Dr. Reynolds in regard to much of the testimony referring to preventing trauma accidents and asked him what the quality of life, percentage of prevention, and at what cost would he estimate trauma care could provide. Dr. Reynolds said currently a certain number of people die, some of whom could be saved. {Tape: 1; Side: B; Comments: Tape Turned.} He stated there is a cost because people will be disabled, however, the riskability could be reduced.

SEN. GROSFIELD commented in regard to Page 10, Lines 14-16 stating the language is very specific and it doesn't exclude standards developed by the Regional Trauma Care Advisory Committee and asked Dr. Reynolds if that was the intention or was the intention to exempt. Dr. Reynolds said they want to develop guidelines which will be actions taken to provide the best possible care. SEN. GROSFIELD asked Dr. Reynolds to comment on releasing data to the patient relating to the patient. Dr. Reynolds said the information available in the patient record is accessible to the patient. He said there needs to be some element of confidentiality when there is a disagreement in regard to quality of care or appropriateness of care. SEN. GROSFIELD clarified that regardless of what the bill says the patient can have access to his records. Dr. Reynolds agreed.

Closing by Sponsor:

REP. WISEMAN gave an example of the difference between a state with a trauma care system and a state without a system. He stated there were no opponents in the House Committee hearing. He urged passage of this legislation.

HEARING ON HB 363

Opening Statement by Sponsor:

REP. EMILY SWANSON, HD 30, Bozeman, presented HB 363 on behalf of the Department of Revenue. REP. SWANSON submitted EXHIBIT 12. She stated the primary goal of this bill was to take motor vehicle taxes and simplify them, increase the efficiency of the licensing process, change current methods, and retain revenue neutrality.

SEN. STANG attested he opposes the amendment. He said a lot of these towns, although resort towns, 85% of the people living in the town are on retirement income.

SEN. FOSTER remarked he supports SEN. VAN VALKENBURG'S motion based on current employment. He stated the issue is tax policy and it should be set by the Montana Legislature.

SEN. ECK responded the legislature for years has advocated it's tax policy responsibilities as far as local government goes.

SEN. GAGE said there are many areas who have problems with their structure, however, just because they are located where they are and aren't tourist attractions they don't have this option.

Vote: MOTION CARRIED 5 - 4 on a roll call vote.

Motion: SEN. STANG MOVED HB 524 BE CONCURRED IN AS AMENDED.

Discussion: SEN. FOSTER announced there is a grant or loan going to Whitefish in HB 8 for a water system. He stated the streets will be torn up real soon. He stressed the people who live in Whitefish already have very high property taxes. SEN. FOSTER said the stack of letters he got were from the residents of Whitefish who don't want this bill.

SEN. STANG affirmed a contribution method will not work. He said this tax has worked well in St. Regis. He insisted this is a win, win situation.

SEN. GAGE maintained there must be a broad base tax in Montana, there just can't be small pockets of taxes.

Vote: MOTION CARRIED 5 - 4 on a roll call vote.

EXECUTIVE ACTION ON HB 591

Motion: SEN. FOSTER MOVED HB 591 BE CONCURRED IN.

Discussion: SEN. GROSFIELD said this is a good bill, however, it needs some fixing and there isn't any funding. He stated there is a federal grant from highway safety funds which may be able to be used.

CHAIRMAN DEVLIN told SEN. GROSFIELD if he wants to work on a mechanism for funding it can be amended on the Senate floor.

SEN. FOSTER commented before the hearing started he visited with Drew Dawson about funding. He said the providers will put up the money.

Motion/Vote: SEN. GROSFIELD MOVED TO STRIKE "OR" AND INSERT "AND" ON PAGE 9, LINE 22. MOTION CARRIED UNANIMOUSLY.

{Tape: 2; Side: B; Comments: Tape Turned.}

Motion: SEN. GROSFIELD MOVED TO AMEND ON PAGE 10, LINE 14, INSERT "OR BY THE REGIONAL TRAUMA CARE ADVISORY COMMITTEE PURSUANT TO SECTION 9".

SEN. VAN VALKENBURG MOVED A SUBSTITUTE MOTION TO STRIKE LINES 14 - 16 OF SUBSECTION 8 ON PAGE 10.

Discussion: SEN. VAN VALKENBURG stated he is suggesting the amendment because clearly standards or protocols that are adopted by the Department of Health should be admissible as evidence in a negligence action.

SEN. ECK agreed with SEN. VAN VALKENBURG in regard to the prohibition being used in the bill.

SEN. FOSTER said this bill should have gone into the Judiciary Committee because we aren't all attorneys in this committee. He said this bill was received late and went through House Taxation which is why it is in Senate Taxation Committee.

Vote: MOTION CARRIED 6 - 1 ON SEN. VAN VALKENBURG'S AMENDMENT WITH SEN. FOSTER VOTING IN OPPOSITION TO THE MOTION.

Motion: SEN. FOSTER MOVED HB 591 BE CONCURRED IN AS AMENDED.

Discussion: SEN. GAGE stated he commends the people who are working in this area, however, he said they can do all of this without the state being involved.

Vote: MOTION CARRIED 6 - 2 on roll call vote.

EXECUTIVE ACTION ON HB 598

Motion: SEN. VAN VALKENBURG MOVED HB 598 BE CONCURRED IN.

Motion/Vote: SEN. ECK MOVED TO AMEND HB 598 LINE 26, INSERTING LANGUAGE REGARDING MAILING NOTICE TO BOTH PARTIES. MOTION CARRIED UNANIMOUSLY.

Motion/Vote: SEN. VAN VALKENBURG MOVED HB 598 BE CONCURRED IN AS AMENDED. MOTION CARRIED 6 - 3 WITH SEN. DEVLIN, SEN. FOSTER, AND SEN. HARP VOTING IN OPPOSITION TO THE MOTION.

MONTANA SENATE
1995 LEGISLATURE
TAXATION COMMITTEE

ROLL CALL

DATE _____

April 5, 1995

[illegible]

Present
a bill &
arrived
9:30 A.M.

SEN:1995
wp.rollcall.man
CS-09

MONTANA SENATE
1995 LEGISLATURE
TAXATION COMMITTEE
ROLL CALL VOTE

DATE April 5, 1995 BILL NO. HB 591 NUMBER _____

MOTION: C.I.A.A.
(2 amendments)

NAME	AYE	NO
GERRY DEVLIN, CHAIRMAN		✓
MACK COLE	✓	
DOROTHY ECK	✓	
DELWYN GAGE		✓
LORENTS GROSFIELD	✓	
JOHN HARP		
BARRY "SPOOK" STANG	✓	
FRED VAN VALKENBURG	✓	
MIKE FOSTER, VICE CHAIRMAN	✓	
	6	2

out

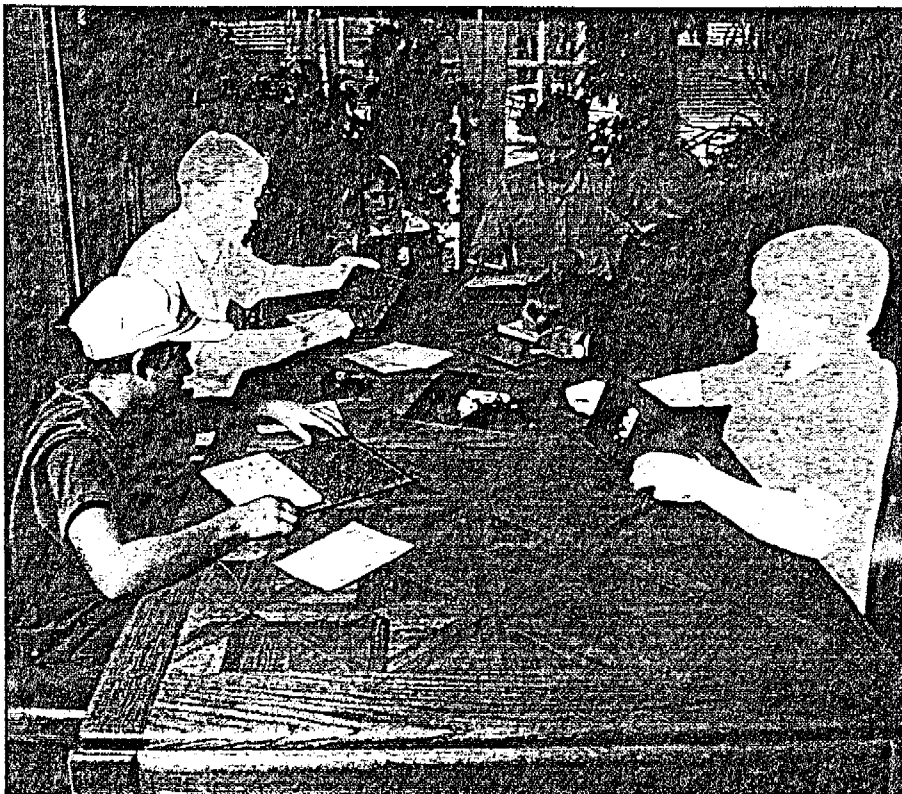
SENATE TAXATION

DATE April 5, 1995

EXHIBIT NO. 1

FILE NO. HB 591

What's missing from this picture?



TRAUMA SYSTEM BILL
FACT SHEET

SENATE TAXATION

DATE April 5, 1985

EXHIBIT NO. 2

BILL NO. HB 591

WHAT DOES THE TRAUMA SYSTEM BILL DO?

- ▶ Allows the Department of Health and Environmental Sciences to establish a voluntary, state-wide trauma system to prevent the occurrence of injuries, to improve the care provided to injured persons, and to reduce Montana's preventable deaths from injury. The legislation is the result of two years of consensus-based planning involving a wide range of health care providers, consumers, hospitals, legislators and others.
- ▶ Establishes regional and state advisory committees to provide a structured method for planning, evaluating and modifying the trauma system based upon data collected by emergency medical services, hospitals and others.
- ▶ Provides legal safeguards and confidentiality protection for hospital and state trauma register data and reports concerning quality improvement and peer review to assure the information can be used in a non-punitive manner to assist hospitals and emergency medical services to voluntarily improve their care.
- ▶ Allows the department to classify medical facilities (based on their voluntary cooperation) according to their capabilities of managing the seriously injured patient.

WHY DO WE NEED TO UPGRADE THE SYSTEM?

- ▶ Trauma is a major killer in Montana - remaining the leading cause of death for Montanans between the ages of 1 and 44. An average of 10 people die from injuries each week in Montana.
- ▶ According to research conducted in Montana, about 20% of Montana trauma deaths could be prevented if there were an organized state-wide trauma system.
- ▶ Injury deaths destroy more years of productive life than all other causes of death combined. The health care costs of trauma care and the economic loss to society are staggering.
- ▶ Organized systems of trauma care have been proven to save lives.

DATE April 5, 1995

BILL NO. HB 591

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA - AN EPIDEMIC; A NEEDLESS TRAGEDY

- ✓ From ages 1 to 44, causes more death than all other causes combined
 - In 1992, there were 346 trauma deaths in this age group
 - In 1992, in this age group there were a total of 261 from all other causes including heart disease, AIDS and cancer
- ✓ In Montana (1992) there were 403 high impact injury deaths among all age groups
 - 174 (43%) of these were motor vehicle-related
- ✓ An organized state-wide trauma system could potentially prevent one to two deaths per week
- ✓ More than \$40 million in direct health care dollars spent in Montana each year.
- ✓ Montana has a high PREVENTABLE death rate - > 2.5 greater than a comparable area of Oregon with an organized trauma system
- ✓ The problem: MONTANA DOES NOT HAVE A TRAUMA SYSTEM

TRAUMA SYSTEMS SAVE LIVES!!

The information below shows, without question, that even the early development of a trauma system, in a rural area, improves the outcome of prehospital and hospital treatment, resulting in a lower percentage of preventable deaths. This doesn't even account for the effect of public education, prevention programs, and repeat training enhancement by medical personnel.

OREGON ATAB-7

Preventability for Hospital Deaths

<i>Combined Data (N=122)</i>		Oregon (n=46)		Montana (n=76)	
PREVENTABILITY		#	%	#	%
Frankly Preventable		3	7%	5	7%
Potentially Preventable		6	13%	19	25%
Total Preventable		9	20%	24	32%
Non-Preventable		37	80%	52	68%



DOT/NHTSA

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

SENATE TAXATION

DATE April 5, 1995

EXHIBIT NO. 4

BILL NO. HB 591

TRAUMA CARE IN MONTANA: WHAT ARE WE DOING ABOUT IT?

- ✓ High trauma death rate
 - Have learned about concept of preventable deaths
 - Completed preventable death studies in Montana
 - Trauma systems reduce preventable deaths
- ✓ State Trauma Task Force formed
 - Montana Trauma System Plan
 - Optimal use of existing resources
 - Facilitate rather than regulate
- ✓ Volunteer efforts have accomplished a great deal
 - Successfully competed for limited federal funding to begin the system
 - Regional Trauma Advisory Committees formed
 - Hospitals starting to form trauma teams and trauma committees
 - Hospitals (15) collecting Trauma Register Data
- ✓ Training with federal funding
 - EMT and First Responder
 - Trauma nurse training in rural areas

TRAUMA SYSTEMS SAVE LIVES!!

WRITTEN TESTIMONY - TRAUMA LEGISLATION,
HOUSE BILL #591; WHY HAVE IT?

SENATE TAXATION

DATE April 5, 19

TEST NO. 5

FILE NO. HB 591

My dear State Senators and fellow Montanans:

I come before you today to speak in favor of House Bill #591. My name is Dr. Robert Hurd. I am a general surgeon in Billings, Montana associated with the Deaconess/Billings Clinic Health System. I've been the Director of the Trauma Service for the last four years. I am a third generation Montanan, being born and raised in Sidney, Montana, and I returned to Montana to devote my career to the health and welfare of fellow Montanans like yourself.

My message is quite simple. A trauma system in this state supported by underlying legislation will save lives, return injured people to work faster after their accident, and finally, save money. This happens because trauma systems reduce the death rate, reduce the severity of injury and get people back on their feet and rehabilitated faster in any state that has a trauma system versus any state that does not have an organized trauma system and legislation. We could see 15% lower costs per hospitalization after an accident. This would save over \$1,000.00 per case. Montana already has dedicated medical professionals and institutions. We have hard working caregivers, and unselfish volunteers who run the majority of our ambulance services. All of us need legislative help to further our efforts.

Why should the state of Montana become involved and pass House Bill #591 during this legislative session? Although many improvements can be made at the local level, a system of care, even a voluntary system, requires a coordinated state-wide and regional approach. This bill establishes a trauma care system and provides some rule-making authority. Although our system is a voluntary one, rule-making authority is essential if we want to improve our care. This authority will come through regional trauma committees, a state trauma committee and a state Emergency Medical Systems Advisory Council. These committees, composed of interested participating caregivers from all over the state, will

provide the core for our state trauma system. House Bill #591 will allow the EMS department to classify or designate hospitals according to their varying capabilities and resources to manage the trauma patient. The bill does not mandate hospitals participate, but rather encourages them to do so. House Bill #591 will also allow for changes in how trauma care is delivered in Montana on the basis of the collection and analysis of reliable data. We need an honest review and evaluation of these data. House Bill #591 will also provide legal safeguards needed to protect peer review data for all of our fellow caregivers at the on a regional basis. Safeguards designed to assure honesty and candor in reviewing trauma data is essential and can only be done through legislation. House Bill #591 will also insure medical direction of local ambulance services to help them achieve their goal of becoming better caregivers. We know that trauma systems will also serve as a good model for regionalized health care delivery systems in all of Emergency Medical Services.

In summary, House Bill #591 will allow us to integrate the resources of caregivers, ambulances, communications, hospital care, triage and transport to make sure that our Montanans who are injured on the road or at the job site will be cared for at the right place at the right time, under the right conditions, with good results. Trauma system development is a team effort. If the legislature delivers the framework through House Bill #591 we health care professionals will do our part to reduce Montana's needless tragedies. Please help us in this endeavor. This will be good legislation which will return both lives and money to our state.

Thank you very much!

Sincerely,

ROBERT N. HURD, M.D.

lp

EXHIBIT 5
DATE 4-5-95
HB 591

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

TRAUMA LEGISLATION: WHY HAVE IT?

- ✓ Formal advisory structure - uses data and Quality Improvement
 - Regional Trauma Advisory Committees (RTAC)
 - State Trauma Committee
 - State EMS Advisory Council
- ✓ Advisory committees are volunteer
 - No expense reimbursement for Regional Trauma Advisory Committees
 - RTACs meeting expenses supported by hospitals
- ✓ Authority to Department to implement a state-wide trauma system and adopt rules
 - Voluntary system
 - Inclusive system including all medical facilities
 - Rules allow for structure to be established - not punitive
- ✓ Designation of hospitals as various levels of trauma facilities
- ✓ Hospital and System Trauma Register
 - Used for Quality Improvement - local, regional and state
 - Confidentiality of Quality Improvement/Peer Review Data
 - Information to "Target" prevention programs
- ✓ Trauma systems - a model for health care delivery

TRAUMA SYSTEMS SAVE LIVES!!



**Montana
Deaconess**

Medical Center

1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

SENATE TAXATION

DATE April 5, 1995

EXHIBIT NO. 6

BILL NO. HB 591

April 5, 1995

Chairman Devlin and Members of the Senate Taxation Committee:

My name is Susan O'Leary and I represent Trauma Coordinators throughout Montana who have been deeply involved in trauma system development in Montana. I have worked as an Emergency Department Nurse for 15 years, and am currently employed by Montana Deaconess Medical Center in Great Falls as a Trauma Coordinator. Those of us employed as Trauma Coordinators have first hand knowledge of what systematized trauma care can provide within our facilities for the trauma patient. Unfortunately, we have been unable to develop a system utilizing and integrating our state resources because we lack a state-wide trauma plan.

I come before you this morning to share why we need a trauma system in our state - what it is and what I can do to improve trauma care, as well as decrease the mortality and disability associated with trauma.

As we in business and government are called upon to do more with fewer resources, system planning has become a prevalent response. A trauma system is an organized, preplanned response to care for a trauma patient. This planning must not be restricted to local planning, but must also include planning on a regional and state-wide basis. With appropriate planning we can assure that the patient will receive good care at the scene of the accident as well as a rapid transfer to the appropriate medical facility best capable of managing their injuries.

In practical terms, what will the Trauma System provide?

There will be a rapid response of well-trained EMT's and First Responders for the trauma victim via 9-1-1. Prehospital personnel will be trained to recognize the severely traumatized patient and will provide rapid treatment and early notification of the local hospital or medical assistance facility.

Because of early notification of an incoming trauma patient, the receiving facility will be able to assemble a trauma team of physicians, nurses, and other personnel necessary to provide prompt, excellent care to the patient. This system will rely heavily on the local physicians and nursing staff to provide life-

saving intervention. A trauma system does not mean that all trauma patients will go to hospitals in larger communities in Montana. In fact, an emphasis of the state trauma plan is to have patients treated in their own community whenever possible to do so.

If the medical needs of the patient exceed the capabilities of the local medical facility, the facility will activate a Central Medical Resource system to coordinate all arrangements for prompt transfer of the patient from one facility to another. These arrangements will provide the quickest transport to the best equipped facility as determined by trauma center designation.

Emphasis on initiating early rehabilitation will assure prompt return of the trauma victim to a productive life.

Collection of state-wide data in the Trauma Register will provide the potential for continual improvement of trauma care in each facility, within the region and on a state-wide basis utilizing a peer review process. However, in order for this process to be beneficial, caregivers must come together in a common, protected forum without fear of legal retribution.

Prevention is a key component of a trauma system. Utilizing the data collected through the Trauma Register, local and regional committees can target specific problem areas for injury prevention and will be able to judge the efficacy of the program on an ongoing basis. If the focus of prevention in your rural community is the use of bicycle helmets but the children are suffering from injuries associated with riding horses, our children will continue to sustain these injuries. Members of the RTAC's have been involved in Health Fairs, prevention programs through local grade schools, alcohol and drug prevention programs through the high schools, and prevention programs for senior citizens. More importantly, we are gathering information on all local and regional injuries. The best planned response to the injured patient will never be as good as preventing an injury to our friends or family.

I would appreciate your support of the Montana Trauma System and House Bill 591.

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

WHY HAVE A MONTANA TRAUMA SYSTEM; WHAT IS IT?

- ✓ Organized , preplanned response to trauma patient - locally, regionally & statewide
- ✓ Rapid response, via 9-1-1, by ambulance services (air & ground). They recognize major trauma patient and communicate to medical facility
- ✓ Medical facility has trauma team (physician, nurse, operating room, etc) ready when patient arrives at their door. This depends of resources of the community.
- ✓ Early surgery often the key to survival
- ✓ If patient's condition exceeds capability of medical facility, Central Medical Resource will quickly coordinate all transportation and transfer arrangements.
- ✓ Match the right patient with the right medical facility in the right amount of time. Time is critically important X
- ✓ Initiate rehabilitation as soon as possible. RETURN PATIENT TO HOME COMMUNITY AS SOON AS PRACTICAL
- ✓ Continual improvements to system by good data and candid critique. RTACs evaluate regional responses and help to make it better

HB 591
DATE 4-5-95
EXHIBIT 9

TRAUMA SYSTEMS SAVE LIVES!!



SENATE TAXATION

DATE April 5, 1995

EXHIBIT NO. 7

SENATE BILL NO. HB 591

MONTANA NURSES' ASSOCIATION

104 BROADWAY, SUITE G-2 - HELENA, MONTANA 59601 - PHONE 406-442-6710

Chairman Devlin and Members of the Taxation Committee,

My name is Sharon Diezger and I represent the Montana Nurses' Association. I'm also a member of the Statewide Trauma Task Force.

I'm speaking in support of House Bill 591. Every day in Montana's Emergency Rooms we are faced with the devastating news that a trauma patient is enroute from somewhere. The long distances and wide open spaces that we enjoy present a real challenge to us when a citizen of Montana becomes a trauma victim. It is not entirely unusual to have them arrive in the back of a pick-up truck. We need to be able to plan with and support even our smallest and most isolated communities. Trauma does not just occur in the cities.

In Montana we are usually faced with blunt trauma vs penetrating trauma - only because right now we don't have as many knife and gun clubs as other states. However, blunt trauma can be just as devastating, and just as debilitating.

A key part of the Trauma System is based on having good data which drives quality improvement. What does this mean? It puts a lot of faith in our interest in providing good care to all patients and to do the right thing. We are up to that challenge.

Although lack of funding is a disappointment, it does not negate the need to have legislation passed that will allow us to build on the system we have already begun to establish.

Quality improvement is a process by which we health care providers establish reasonable goals or standards designed to improve patient care. By collecting good data, we can determine if we are meeting those goals. If we aren't, we must figure out together where the problems lie and how we can fix them.

Chairman Devlin and Members of the Taxation Committee
(continued)

Statewide quality improvement data will be provided to the State Trauma Committee which will review data and work with regions and individual services to make improvement. They will assess and act on the information and use the data for future system improvements.

Recognizing the importance of the candor and honesty afforded by quality improvement, the legislature has previously provided "peer review" legal protections to in-hospital committees. House Bill 591 provides the same legal protections to the Regional Trauma Advisory Committees, the State Trauma Committee and the Department. Their ability to use data for quality improvement is essential to the operation of the Montana Trauma System.

Only individual patient care data reports used for quality improvement are protected. General information not identified by facility and not used for quality improvement are not protected and are considered as public information. All of the original patient care information is, of course, discoverable by the usual legal methods.

The plan you have before you represents the state's battle plan in the war against trauma. The Montana Trauma System organizes, integrates and refines existing health care resources throughout the state to provide improved care of injured patients. Saving lives and saving money are certainly worthwhile goals for the State of Montana to consider. An affirmative vote for House Bill 591 is vital. It will make a difference.

Thank you for your time.

EXHIBIT 7
DATE 4-5-95
HB 591

HOUSE BILL 591

AN OUTLINE OF TESTIMONY

QUALITY IMPROVEMENT - THE BASIS OF THE TRAUMA SYSTEM

- ✓ Use of data to evaluate how well we are doing and to make improvements when needed
- ✓ Health care professionals must honestly discuss the trauma data and figure out solutions
 - To be successful, it must be done without fear of legal discovery
 - "Fix" problems by education and training - not punishment
- ✓ Hospital and system trauma registries are our data collection tools
 - Used by hospitals, Regional Trauma Advisory Committees, and state EMS
 - HB 591 provides legal protection to the Quality Improvement portion of the data
 - Original patient records are still discoverable

TRAUMA SYSTEMS SAVE LIVES!!

HOUSE BILL 591

HIGHLIGHTS OF TESTIMONY

TRAUMA SYSTEM: IMPACT ON PREHOSPITAL CARE PROVIDERS

- *** EMS Advisory Council provides a structured method for prehospital provider input to state wide decisions - This is currently lacking
- *** Provides a method for prehospital care providers, physicians and nurses to work together to preplan response to trauma - locally and regionally
- *** Enables "peer review" to occur without fear of legal discovery - essential for honest evaluation and improvement
- *** Improved medical involvement in prehospital care through the Local Trauma Committees and Regional Trauma Advisory Committees created by the Montana Trauma Plan
- *** Trauma registry data will isolate specific areas requiring public education. Prehospital care providers can then target these areas for their prevention and public education activities.
- *** Improve communications, coordinations and teamwork between all patient care providers.

HB 591 TESTIMONY

SENATE TAXATION COMMITTEE

Chairman and members of the committee, my name is Gary Haigh. I'm a prehospital care provider currently living in Billings. For the past five years I've had the privilege of representing the Montana Emergency Medical Services Association in statewide trauma system development activities.

First I'd like to tell you why I'm here: In 1979 a group of friends and I went to watch an Ennis Mustangs football game in another rural Montana town. During the game a player and good friend, made a bone crunching tackle but failed to rise. The coach, one of the early EMT's in the state assessed him where he lay and determined that there was no feeling in the legs, indicating a spinal injury. An ambulance was called for only to find out the town didn't have an ambulance, hospital or doctor. My friends and I, who had basic first aid training, hauled the injured player ninety miles in the back of a station wagon watching the paralysis spread to more and more of his body. When we arrived at the hospital they were unprepared for our arrival and unable to provide the care needed resulting in transfer to another facility then to another facility, further delaying definitive care. This convinced me to become involved in EMS and work towards the creation of a better system. My friend the football player was lucky he recovered enough to become a productive member of society. Would his recovery have been closer to complete with this legislation in place? I have no doubts it would have been. Would the medical and rehabilitation costs been less? Markedly so!

How will this legislation effect prehospital care providers?

There are over 5000 prehospital care providers in Montana. Unlike physicians, nurses, respiratory therapists, dentists, PA's, and most other professional areas prehospital personnel have no structured method for input to the agencies that govern and regulate them. These First Responders and EMT's, mostly volunteers, deserve the opportunity to express and have their opinions heard. By establishing the EMS Advisory council this legislation will create a method for structured input from the people in the trenches doing the work.

Previous testimony has described why preplanning the care of trauma patients is important. This planning must be done not only at the facility or trauma center level but also at the prehospital level. If facilities and prehospital care entities each develop their own plan, will the plans work together?? HB591 provides a structure where prehospital care providers, nurses, physicians, and facilities work together to determine ahead of time which patients are critical and require activation of the trauma team and/or require transport to another facility. This coordination will expedite appropriate care for trauma patients.

To learn from our mistakes we must be able to view the whole picture to see how each part affects the other parts. Many facilities and many ambulances review cases, but seldom do they review them together, thus neither sees the whole picture. One reason this does not occur is the lack of protection from discovery. Trauma system legislation provides protection from discovery and creates a structure where "peer review" will be conducted at both the local and the regional level.

In many areas of our state the medical community has little or no involvement in prehospital care. Each party shares the blame for this situation but it is the patient who suffers the consequences. Locally and regional trauma committees established by the trauma plan will serve as a forum to increase involvement by the medical community and prehospital providers.

Most ambulance services and quick response units are involved in public education and prevention activities on a local basis. The question has always been are these activities the right ones. The data from the trauma registry will isolate specific areas where public education can have the greatest impact on decreasing trauma. Prehospital and hospital can then work together to present prevention education that will target these areas, providing the maximum effect for the effort and money.

In summary the trauma system will effect prehospital care providers by improving communications and coordination between all members of the patient care team. The team is now disjointed but willing to work together, what we need is a framework that promotes that promotes teamwork. This legislation is that framework.

Thank you for your support of this life saving legislation.



Montana Emergency Medical Services Association

P.O. Box 236
Roy, MT 59471
(800) 247-2369

SENATE TAXATION

DATE April 15, 1995
EXHIBIT NO. 9
BILL NO. HB 591

DATE: April 5, 1995

TO: Senate Taxation Committee
Chair
Committee Members

SUBJECT: Testimony Concerning HB591, Statewide Trauma
Care System

The Montana Emergency Medical Services Association Inc. (MEMSA) is the professional organization of pre-hospital care providers in our state. The majority of our members are associated with rural volunteer emergency medical service (EMS) entities. MEMSA members reside in over 40 of Montana's counties.

The effects of a statewide trauma care system will be improved communications, coordination and cooperation for all members of the patient care team. The end result being that fewer of our friends and neighbors will die as a result of trauma and the effects of the trauma will be mitigated for those who are injured.

Montana, being a rural, sparsely populated state, depends on volunteer emergency medical services organizations to assure that EMS is available when needed. These organizations strive to provide high quality and efficient service for their friends, neighbors, and others. These volunteers deserve to have input into decisions that effect the operation of their emergency medical services organizations. This legislation will create a structured method for the volunteers, who are out there doing the work to express their opinions, ideas and frustrations.

At the 1994 meeting of the MEMSA membership a resolution in support of the statewide trauma system was introduced and endorsed by a large majority of the members. (Attached)

MEMSA would like to see the funding reinstated. However with or without the funding our organization supports this bill and urges you as a committee to give it a "DO PASS" recommendation.

John Gervais
President



RESOLUTION ON TRAUMA SYSTEM AND TRAUMA SYSTEM LEGISLATION

Whereas, trauma is the leading cause of death and disability in children and young adults; and

Whereas, trauma is a significant problem in the state of Montana; and

Whereas, other areas have demonstrated that an organized system for trauma care will reduce death and disability; and

Whereas, reducing death and disability from trauma will reduce medical costs; and

Whereas, the Montana Trauma System Plan will provide for input and representation by pre-hospital care providers; and

Whereas, data collection will provide information on how prevention and care of trauma patients can be improved; and

Whereas, communications between all levels of care providers will be improved by the trauma system; and

Whereas, a trauma system will promote and/or provide specialized training for all providers; and

Whereas, a systematic approach to trauma care will improve consistency of care and operations; and

Whereas, the trauma system will provide limited funding to improve trauma prevention and care at all levels; and

Whereas, an objective of the Montana Emergency Medical Services Association is to reduce trauma and promote quality care; and

Now, therefore, the Montana Emergency Medical Services Association hereby resolves to support the Montana Trauma System Plan and legislation designed to implement the plan.

DATE April 5, 1991EXHIBIT NO. 10BILL NO. HB 591NAME Steve YeakerADDRESS PO Box 46623 Helena 59604HOME PHONE _____ WORK PHONE 443-1674REPRESENTING Montana Council for Maternal & Child HealthAPPEARING ON WHICH PROPOSAL? HB 591DO YOU: SUPPORT ☒ OPPOSE _____ AMEND _____

COMMENTS:

Of all deaths to Montanans between 1986-1990,TRAUMA caused44% of the deaths to children age 1-467% of the deaths to children age 5-1460% of the deaths to children age 15-24

A system for trauma care, such as the one proposed in HB 591,
can prevent death to children from injury, reduce the lifetime costs
of serious injury, and reduce the potential for lost quality of life
due to injury.

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY



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GREAT FALLS, MONTANA 59403 (406) 727-3333

SENATE TAXATION

DATE -- April 5, 1995

COMMITTEE NO. 11

BILL NO. 4/B591

TO: Sen. Gerry Devlin, Chairman
Senate Taxation Committee
FROM: Columbus Hospital, E.D.
Great Falls, MT

4/3/95

Senator Devlin your support of House Bill 591 would be greatly appreciated. A statewide Trauma Care System is needed.

Thank you

Adele Borchardt R.N.

Adele Borchardt, R.N.
Columbus Hospital Trauma Coord.

Brian Christensen R.N.

Brian Christensen, R.N.
Columbus Hospital Emergency Dept. Supervisor.

SENATE STANDING COMMITTEE REPORT

Page 1 of 1
April 6, 1995

MR. PRESIDENT:

We, your committee on Taxation having had under consideration HB 591 (third reading copy -- blue), respectfully report that HB 591 be amended as follows and as so amended be concurred in.

Signed: Sen. Devlin
Senator Gerry Devlin, Chair

That such amendments read:

1. Page 9, line 22.

Strike: "or"

Insert: "and"

2. Page 10, lines 14 through 16.

Strike: subsection (8) in its entirety

-END-

 Amd. Coord.
Sec. of Senate

Sen. Foster
Senator Carrying Bill

790948SC.SPv